Moving on from ‘Listening Visits’: a mixed methods, multi-phase study exploring the support that health visitors provide to mothers with mental health problems.

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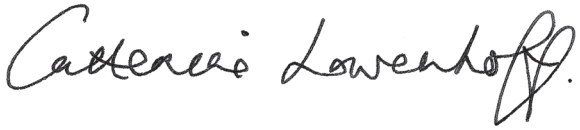
Statement of originality

This is to certify that to the best of my knowledge, the content of this thesis is my own work.

This thesis has not been submitted for any de-gree or other purposes. I certify that the intellectual content of this the-sis is the product of my own work and that all the assistance received in preparing this thesis and sources have been acknowledged.



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Abstract

'Childbearing is attended by a plethora of psychiatric disorders, which make pregnancy and its aftermath the most complex event in human experience.' (**BROCKINGTON ET AL, 2017 P.114**)

It is estimated that at least 50% of the 25% of mothers who experience mental health problems (MHPs) during pregnancy or the year after they have a baby (the perinatal period) are not getting the help they need that will lead to recovery. Children of mothers with untreated MHPs are more likely to experience physical and mental health problems throughout their lives. Preventing and treating maternal mental ill-health therefore has the potential to improve the health of two generations.

Health visitors (HVs) have routine contact with all mothers during the perinatal period and, since 1989, have been providing an intervention described as 'listening visits' (LVs) to mothers with postnatal depression. When the NICE guideline for antenatal and postnatal mental health was updated in 2014, LVs were not included as one of the recommended evidence-based interventions for mothers with perinatal depression. This created confusion about what HVs should be doing and provided the catalyst for this PhD study.

The initial aim of the study was to understand why LVs had been omitted from the guideline and what this meant for HVs. An online survey to explore current practice was devised and completed by 1599 health visitors March – May 2016. This exposed a range of factors that influenced the capacity of HVs to provide the support that they thought was needed. The survey revealed variations in the interpretation and delivery of LVs and a disconnect between the definition of LVs used in the NICE guideline and the reality of HV practice. A clear message from the survey was that HVs wanted to feel confident and competent in their ability to deliver an evidence-informed perinatal mental health intervention that was clearly defined in terms of its structure, content and purpose. As well as better training, the majority of survey respondents wanted a manual to guide their practice to ensure the provision of consistent, standardised care. This led to the decision to extend the PhD study to explore the possibility of developing a manual.

An enriched version of the development phase of the MRC guidance for complex interventions was used to provide the framework for this emergent, mixed methods study. As well as an examination of current practice and context, a series of literature reviews were undertaken to provide information on the scale and impact of perinatal mental health problems; the common components of effective interventions delivered by non-mental health specialists to community-based mothers with MHPs; the theories that might help to inform or explain why mothers become mentally unwell and what might help them to feel better; and the views of mothers and HVs regarding their experiences of perinatal mental illness and care.

The intention of the study was to combine evidence from research with the wisdom of HVs to develop a feasible, acceptable, effective, manualised intervention. The penultimate stage of the research involved recruiting a group of expert HVs (n=27) to participate in a modified, technological, real-time Delphi study that took place over six face-to-face meetings between February 2016 and June 2017. The expert HVs reviewed the accumulated intelligence that had accrued from all the previous phases of the study and collectively agreed what should be included in the prototype manualised guide for HV perinatal mental health practice. The expert HVs reviewed the prototype that was produced and concluded that it represented an innovative evidence-based approach that they were keen to use to inform the support that they provided to mothers in their care.

Unique aspects of the prototype include the integration of assessment with intervention, the emphasis on strengths and resilience as well as deficit and risk; consideration of the interplay between physical and mental health, recognition of the need to promote positive mental health as well as treat mental ill-health; acknowledgement of the importance of considering and ameliorating the impact of maternal mental health on interactions with significant others; and the inclusion of a range of therapeutic options that can be tailored to the needs, preferences and circumstances of individual mothers. As there is nothing like it that currently exists, the prototype guide for practice, and the way that it has been developed and presented, represents an original contribution to the body of knowledge.

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APA	American Psychiatric Association
CC	Core components
DH	Department of Health
DMM	Distillation and matching model
GAD	Generalised Anxiety Disorder
HV	Health visitor
IAPT	Improving Access to Psychological Therapies
IHV	Institute of Health Visiting
IOM	Institute of Medicine
KCA	Key clinical activities
LVs	Listening Visits
MHP	Mental health problem
MPSE	Maternal Parental Self-Efficacy
MRC	Medical Research Council
MW	Midwife
NCCMH	National Collaborating Centre for Mental Health
NDC	Non Directive Counselling
NICE	National Institute for Health and Care Excellence
OCD	Obsessive Compulsive Disorder
PrA	Pregnancy specific Anxiety
PND	Postnatal depression
PTSD	Post Traumatic Stress Disorder
RCTs	Randomised Controlled Trials
TDF	Theoretical Domains Framework

Chapter 1. Introduction: ‘Moving On’ from ‘Listening Visits’

1.1 Introduction

The primary purpose of this chapter is to explain why this thesis is entitled 'Moving On From Listening Visits' and why it is necessary to explore the support that health visitors (HVs) provide to mothers with mental health problems (MHPs). The reasons why maternal MHPs represent a significant public health issue, and therefore a problem that needs to be addressed are summarised in section 1.2. The role of HVs in identifying and supporting mothers with MHPs is described in section 1.3. What 'Listening Visits' (LVs) are and why we need to consider 'moving on' from them, is covered in sections 1.4 and 1.5. Gadamerian hermeneutics is introduced in section 1.6 to explain the philosophical assumptions underpinning the choice of topic, the relevance of personal professional experience, and the consequent focus and design of the research. Subsequent sections in this chapter summarise the research questions, the aims and objectives of the PhD study and the theoretical framework that guides the research process. This chapter will conclude with an outline of the whole thesis.

1.2. What is the problem that needs to be addressed?

The problem that needs to be addressed is the mental health of mothers during pregnancy and the year after having a baby (the perinatal period). This period represents a time of heightened risk for the exacerbation, or continuation, of pre-existing MHPs or a first experience of a MHP **(AUSTIN ET AL, 2014)**. Mental health problems are among the commonest morbidities experienced by mothers in the perinatal period and a significant cause of maternal deaths **(HOWARD & KHALIFEH, 2020)**.

The most common perinatal mental health problems are depression and anxiety. These two conditions are often co-morbid with each other **(BIAGGI ET AL, 2016)**, but may mask other difficulties (such as intimate partner violence or substance misuse) or overlap with more complex or severe disorders **(VIGOD ET AL, 2016)**. Some anxiety disorders, such as Obsessive Compulsive Disorder (OCD) **(MCGUINESS ET AL, 2011)** and Post Traumatic Stress Disorder (PTSD) **(DIKMEN-YILDEZ ET AL, 2017)** are sometimes misdiagnosed as depression. Some women experience symptoms that cause significant psychological distress that are not included in diagnostic criteria (such as anger, irritability, detachment and social withdrawal).

Perinatal MHPs is a collective term used to describe any MHP or sub-threshold constellation of mental illness symptoms that mothers might experience during pregnancy or the year following delivery. At least 25% of women are affected worldwide, although prevalence estimates vary according to the timing of the assessment and the tools used to assess symptoms and determine diagnoses **(HOWARD & KHALIFEH, 2020; O'HARA & WISNER, 2014)**.

The combination of the difficulties in diagnosing maternal MHPs, the stigma associated with mental ill-health (exacerbated in the perinatal period by the myth of universally joyous motherhood), and the challenge of differentiating symptoms of mental ill-health from symptoms associated with the transition to parenthood, makes it more difficult for mothers, and others, to recognise when additional support is required. This may partially explain why at least 50% of mothers who experience MHPs are not being identified and/or are not getting the help that they need that will lead to recovery **(COX ET AL, 2016)**. If not detected and treated, mothers may suffer from repeated episodes of mental ill-health that can last a lifetime **(O'HARA & MCCABE, 2013; VLIEGEN AT AL, 2014)**.

Maternal depression increases the likelihood of depression in the partner **(DON & MICKELSON, 2012)**. Conversely, depression in fathers can increase the likelihood of ongoing or deteriorating mental illness in the mother **(PAULSON ET AL, 2016)**. Dissatisfaction with the partner relationship is associated with both maternal and paternal perinatal depression **(DON ET AL, 2014; GAWLIK ET AL, 2014)**. It has been estimated that at least 10% of fathers experience perinatal anxiety or depression **(LEACH ET AL, 2016; PAULSON & BAZEMORE, 2010**) The mental health of fathers/partners is obviously important. However, as it is mothers who have most frequent contact with health professionals during pregnancy and the first postnatal year, and it is mothers who are most likely to be responsible for nurturing the foetus/infant during this period, they are the focus of this PhD programme of research.

Another reason why it is important to identify mothers with mental health problems at the earliest possible opportunity is because of the potential impact of maternal mental ill-health on the way that the mother thinks about, interacts with, cares for, and comforts her baby. Difficulties in interpreting and responding to infant needs can lead to adverse consequences for the baby across the lifespan, such as emotional and behavioural problems in childhood and adolescence, and mental health problems in adulthood.

Nearly three-quarters of the annual cost of untreated perinatal mental health problems in the UK (estimated at £8.1 billion) is attributable to the long-term impact on the child **(BAUER ET AL, 2014)**. A national retrospective cohort study linking UK GP practice data for mothers (n=381,685) and children (n=547,747) indicates that the prevalence of maternal mental illness is increasing , and more children are adversely affected **(ABEL ET AL, 2019)**. The proportion of children, aged 0 – 16, exposed to maternal mental illness has increased from 22.2% between 2005 and 2007 to 25.1% between 2015 and 2017 **(ABEL ET AL, 2019)**. Although not all children exposed to maternal mental illness experience negative outcomes, adverse sequelae can occur even if mothers do not meet the criteria for a diagnosable mental illness **(GIALLO ET AL, 2015; KINGSTON ET AL, 2018)**.

The prevalence of emotional and behavioural problems in children is also steadily increasing. According to a survey (n = 9,117) carried out by The National Centre for Research in 2017, 5.5% of 2-4 year olds and 10.8% of 5-16 year olds had at least one diagnosable disorder **(NHS DIGITAL, 2018)**. In 2020, prevalence for 2-4 year olds was not available, but the prevalence had increased to 16.0% for children aged 5 to 16 years **(NHS DIGITAL 2020)**. The Health Care system is unable to provide support for all these children. A report produced by the Education and Policy Institute in 2018 found that the rate of referrals to specialist Child and Adolescent Mental Health Services (CAMHS) in England increased by 26% over the preceding 5 years. Between one fifth and one quarter of children and young people referred to CAMHS did not meet the referral criteria for the service and therefore did not receive any specialist support **(CRENNA-JENNINGS & HUTCHINSON, 2018)**. Identifying and supporting mothers who may be at risk of, or experiencing mental ill-health, therefore has the potential to improve outcomes for both mothers and babies and reduce the burden on specialist services as those babies progress through life.

It has also been suggested that there may be a link between maternal perinatal psychological distress and other adverse sequelae such as: childhood gastro-intestinal and lower respiratory tract infections; asthma; obesity; global developmental delay; increased rates of accidental poisonings, fractures and burns; child abuse and neglect; and reduced vaccination uptake **(BAN ET AL, 2010; BAKER ET AL, 2017; ENTRINGER ET AL, 2015; HEERMAN ET AL, 2016; HOPE ET AL, 2019; KINGSTON & TOUGH, 2014; MAGNUS ET AL, 2017; OSAM ET AL, 2020; SIDEBOTHAM ET AL, 2016)**.

The mental health of the mother is inextricably entwined with the wellbeing of the infant. The return on investment of identifying and treating maternal MHPs is significant because of the large number of mothers who are affected every year and 'the potential to reach across generations by improving the health of at least two individuals.' **(WEIS & RENSHON, 2019. P.E268).**

1.3. Why is it appropriate for health visitors to be involved in assessing and managing maternal mental health problems?

The NICE guideline for antenatal and postnatal mental health states that 90% of mothers who experience MHPs can be treated by primary care professionals such as GP's, midwives and HVs **(NICE, 2014A).** A health visitor is an experienced nurse or midwife who has undertaken a further year of training in public health nursing. HVs visit all families during pregnancy and the first five years of a child's life in order to promote and support the health, development and safety of the children, and the wellbeing of all members of the family. In England, The HV is the only health professional who is mandated to make contact with every family on 4 occasions from pregnancy until the infant is 1 year old **(DEPARTMENT OF HEALTH (DH) 2009).** As public health nurses, HVs promote emotional well-being, prevent the development or escalation of MHPs, identify symptoms of mental health at the earliest possible opportunity, consider the impact of mental ill-health on relationships and activities, and enable access to prompt, appropriate, effective and acceptable interventions when needed **(MALONE ET AL, 2016).**

Mothers are much more likely to share their innermost thoughts and feelings with a health professional (such as the HV) with whom they have developed a trusting relationship, and whom they believe has the necessary knowledge and skills to be able to help them **(COWLEY ET AL, 2015; HENSHAW ET AL, 2011).** It therefore follows that HVs, with the right kind of training, supervision and support, have a unique opportunity to improve the identification and treatment of mothers with MHPs, to reduce the impact on the child, and to promote family resilience and emotional well-being **(CHOI ET AL, 2020).** The Department of Health has recognised this aspect of HV practice by designating maternal mental health as one of 6 early years high impact areas. These are areas where it has been demonstrated that support from HVs leads to improved health outcomes for families **(DH, 2014A).**

1.4. What are 'Listening Visits?'

'Listening Visits' were introduced in 1989 in response to growing concerns about the number of women with postnatal depression (PND) who were not being identified, or receiving the help that was needed, that would lead to recovery **(HOLDEN ET AL, 1989).** The original protocol specified that HVs should use non-directive counselling (NDC) techniques, during the course of 8 weekly home visits, to explore maternal thoughts, feelings and concerns, in order to help the depressed mother to reach her own conclusions about what might help her to feel better **(HOLDEN ET AL, 1989).** The HV would then motivate and support the mother to enact maternally-generated solutions. This intervention culminated in clinically and statistically significant reductions in symptoms of PND **(HOLDEN ET AL, 1989).** Other descriptive terms used interchangeably with NDC include humanistic therapy or person-centred care.

The intervention described as LVs has been modified over time in response to the changing body of knowledge regarding the causes, symptoms, prevalence and impact of maternal MHPs, the interventions and modes of delivery that might be acceptable and effective and the contextual factors that might compromise or enhance intervention delivery and outcomes **(HAUCK ET AL, 2015; HOWARD & KHALIFEH,**

2020; O'HARA ET AL, 2014). Rather than providing an intervention solely for mothers with PND, there is an expectation that HVs will also assess and respond to the needs of mothers with mild to moderate presentations, or sub-threshold symptoms, of any common MHP, and who might present during pregnancy, or at any time up to one year post-birth.

Modifications of LVs have occurred such as a reduction of the number of visits that constitute the package of care; the inclusion of other techniques such as those used in cognitive behavioural therapy, motivational interviewing, the skilled helper model, or brief solution focussed therapy; and a greater focus on maternal -infant interaction, infant well-being and the mental health of partners **(APPLEBY ET AL, 2003; COOPER ET AL, 2003; MORRELL ET AL, 2009; PAULSON ET AL, 2006; SEELEY ET AL, 1996; SHARP ET AL, 2010)**. These modifications have meant that LVs has become an umbrella term for a generic intervention that does not always conform to the original LV protocol **(HOLDEN ET AL,1989)**. Evidence from qualitative research implies uncertainty about the core components, intended outcomes, and acceptability of LVs amongst both mothers receiving them, and health visitors delivering them **(CUMMINGS & WHITTAKER, 2016; MORGAN, 2017; SHAKESPEARE ET AL, 2006; SLADE ET AL, 2010; TURNER ET AL, 2010)**.

1.5. Why we need to consider 'moving on' from 'Listening visits.'

Uncertainty about the content, effectiveness and acceptability of LVs was further exacerbated when the NICE guideline for antenatal and postnatal mental health was updated in December 2014 **(NICE, 2014A)**. The recommendation from the 2007 version of the guideline **(NICE, 2007A)**, to offer LVs to mothers with mild to moderate postnatal depression, was not included **(NICE, 2014A)**.This was unexpected as the largest pragmatic randomised controlled trial (the PoNDER trial) that appeared to demonstrate the effectiveness of HV interventions (based on either a person-centred or cognitive-behavioural approach), to improve outcomes for mothers with postnatal depression, was reported in 2009 **(MORRELL ET AL, 2009)**. However, the PoNDER trial, in common with the majority of perinatal mental health research prior to 2014, focussed exclusively on interventions for mothers with postnatal depression. It is not known whether these interventions are effective for mothers experiencing MHPs, other than PND.

The 2012 Health and Social Care Act requires commissioners and providers of services to comply with the recommendations in NICE guidelines **(LOCAL GOVERNMENT ASSOCIATION, 2012)**. The omission of LVs from the NICE guideline created a disorienting dilemma **(MEZIROW, 1978)** for commissioners, managers and HVs. It was difficult to ascertain the implications of the updated guideline for health visiting perinatal mental health practice and, more specifically, for commissioners and managers to decide whether it was appropriate to support HVs to continue to deliver LVs. Commissioning decisions were further influenced by cuts in public health budgets that accompanied the transfer of the commissioning of health visiting services to the Public Health Departments of Local Authorities (LAs), in October 2015. The required efficiency savings often culminated in reductions in the number of health visitors employed, or restrictions to their scope of practice. In some LAs, the responsibility for providing perinatal mental health care, to mothers with mild to moderate MHPs, was devolved to other services. This added to the confusion about whether HVs should be supporting mothers with MHPs and, if they were expected to provide support, what that support should entail.

A briefing paper produced by the institute of Health Visiting (iHV), in response to the launch of the updated NICE guideline **(NICE, 2014A)**, suggested that HVs were using a range of strategies and techniques in the support that they provided to mothers with MHPs. The iHV suggested that these could all be construed as variations of facilitated self-help **(IHV, 2014)**. The relevance of the use of this descriptive

term was that facilitated self-help was the recommended intervention, in the updated NICE guideline, for mothers with mild to moderate perinatal anxiety or depression **(NICE, 2014A)**. The iHV proposed that if HVs were offering a LV intervention that could be perceived as facilitated self-help, then they complied with the NICE guideline recommendations, and could continue to offer LVs.

However, there was a pre-existing expectation that Improving Access to Psychological Therapy (IAPT) Services, established to provide facilitated self-help to all individuals with common MHPs, should embrace the responsibility of providing support to mothers with perinatal MHPs **(DEPARTMENT OF HEALTH (DH), 2009; JOINT COMMISSIONING PANEL FOR MENTAL HEALTH, 2012)**. Guidance that was updated in 2018 designated IAPT services and GPs as the preferred providers of support for mothers with mild to moderate MHPs **(PUBLIC HEALTH ENGLAND (PHE), 2018A)**. Following the launch of the updated NICE guideline it was therefore unclear how HVs should comply with the NICE guideline and fulfil their obligations, described in the second of the six early years high impact areas **(DH, 2014A)**, to identify and support mothers with MHPs.

1.6. Choice of topic

In Gadamerian hermeneutics the combination of circumstances that brings a topic to the forefront of one's attention is described as 'The Address.' **(GADAMER, 1960/1989, P. 299)**. The Address 'functions to interrupt or unsettle our everyday taken-for-grantedness of things' **(MOULES ET AL, 2014 P.2)**. The disruption can take the form of growing awareness that something isn't quite right or isn't working in the way that it should, or as a result of a specific incident. 'The Address' in this case was the exacerbation of the underlying confusion about what is meant by LVs, by the omission of LVs from the updated NICE guideline for antenatal and postnatal mental health **(NICE, 2014A)**.

The reference to Gadamer in the previous paragraph is deliberate because Gadamerian hermeneutics explains the philosophical assumptions underpinning this research. Gadamer's emphasis on the ontological mode of 'being' rather than the epistemological mode of 'knowing' is reflected in his focus on learning from 'life as it is lived' and his assertion that 'phronesis' (practical wisdom) is central to the act of understanding **(VANDERMAUSE, 2008)**. The philosophical assumptions are introduced at this point in the thesis because of the attributed importance of 'phronesis' in hermeneutic enquiry, both in the formulation of the questions, and the selection of research methods.

Hermeneutics has been defined as the 'tradition, philosophy and practice of interpretation' **(MOULES, 2002. P.2)**. As hermeneutics is a matter of interpretation, variations of this definition also exist! Philosophical hermeneutics provides an interpretive frame that acknowledges the influence of culture, tradition and experience, on the way that individuals understand the meaning conveyed by spoken or written words. For example, the meaning that I am trying to convey by the words that I have written in this thesis may be interpreted differently by different individuals, depending on their own heritage and perspective, and their specific reasons for engaging with the text! Gadamer (1960/1989) proposed that 'the light that causes everything to emerge in such a way that it is evident and comprehensible in itself is the light of the word' (p. 478). As relational beings, language provides the mechanism for how we describe ourselves and our world to each other. 'To be conversant is our way of being' **(BROGAN 2020, P.3)**. Interpretation therefore begins with reflection, in terms of contemplation of both the intended, and interpreted, meaning of words.

Hermeneutic enquiry starts with what is known and then endeavours to expose, through interpretation and reflection, that which is hidden or forgotten **(MOULES ET AL, 2014)**. Through multiple avenues of investigation a hermeneutic researcher seeks to harmonise multiple interpretations in order to re-appraise, re-animate, or re-imagine, a topic **(MCCAFFERY ET AL, 2012)**. Thirsk & Clark (2017) use the example of people sitting round a table to illustrate this point. The purpose of asking participants about their experience is not to find out from them what it is like to sit at the table but to ascertain what additional information we can learn about the table (topic) from their collective experiences! A different set of people sitting around the table may provide additional insights that alter and further enhance the researcher's perception of the table. This example illustrates two key concepts of hermeneutic enquiry: the hermeneutic circle and the fusion of horizons.

The hermeneutic circle proposes that it is only possible to understand the whole if one understands the parts, and one can only understand the relevance of the parts if one understands the whole **(MOULES, 2002)**. Understanding of the whole and the parts, and how they fit together, is influenced by one's own learning and cultural background described by Gadamer as 'historically effected consciousness' **(GADAMER 1960/1989 P.336)**. Prior knowledge and experience inevitably influence the way an individual interprets, and makes sense of, what they discover in the dynamic to-and-fro examination of the interplay between the parts and the whole. Through dialogue with text or individuals a researcher considers the perspectives of others and, as a consequence of this 'fusion of horizons', reaches new understanding **(MOULES, 2002)**. It is not simply about adopting the views of others but synthesizing the views of others with personally held views to reach a 'new' horizon. Another individual with different experiences, knowledge, and ideas may have a different interpretation of the same phenomena. It is important to recognise that we are all likely to 'see' things differently, and when exposed to the same inputs may arrive at different endpoints. Those endpoints are not finite. The horizon of interpretation is in a state of continual flux.

Interpretation is therefore always informed by what is already consciously or subconsciously known by the interpreter **(MOULES, 2002)**. Heidegger describes this as a 'forestructure of understanding' **(HEIDEGGER, 1996. P.141)**. Gadamer refers to this phenomenon as 'pre-judgement' or prejudice **(GADAMER, 1960/1989 P.27)**. The researcher is both guided and constrained by their prejudices. In hermeneutic inquiry, this can be an asset, not a handicap, as the researcher is a collaborative participant in the generation of meaning and understanding **(AGREY, 2014)**. Gadamer maintains that it is not possible to eliminate prejudices, but it is important to bring them into focus both before, and during, participation in research, in order to increase awareness of how they might influence understanding **(MOULES, 2002)**. Moules (2002 p.12) argues that because our prejudices are 'intricately woven into the fabric of our lives, our beliefs and our behaviours' we are probably most influenced by the prejudices that we have no idea that we possess. Nevertheless, as philosophical hermeneutics is considered a form of reflective, interpretive inquiry concerned with understanding the world in the context of multiple sources and influences on that understanding (including the researcher's sense of 'being-in-the-world'), it is appropriate for a researcher to declare the experiences that influence their prejudices.

My concern about the potential impact of the omission of LVs from the updated NICE guideline arises from my clinical career, first as a health visitor, and then as a nurse consultant in perinatal and infant mental health. From the perspective of a HV I cannot see how it is possible to consider all the factors that might influence the health, safety and development of a child without considering the health and wellbeing of the mother. I believe that HVs, because they have access to all mothers, should play an

important part in identifying and supporting mothers experiencing, or at risk of, mental ill-health, including the 50% that we are currently failing to reach. I believe that HVs either already have, or could have, the skills, knowledge and opportunity to address some of the underlying issues that predispose to, or precipitate, maternal psychological distress, and can consider and address the impact of maternal mental ill-health on all members of the family. I believe that the role of the HV in alleviating the burden of maternal mental ill-health and its consequences is not understood or valued by other professionals, managers, commissioners or policy-makers. However, I also believe this misunderstanding arises from uncertainty amongst HVs themselves about what they should be doing and how they should, or could, be doing it, particularly with reference to the delivery of LVs.

As a health visitor, although I had received some training in how to deliver LVs, I never really felt confident and competent that I was doing the right thing. I was also aware, at that time, that several of my health visiting colleagues shared my sense of not really knowing how they were supposed to deliver LVs. This sense of professional insecurity stimulated my desire to improve my knowledge, skills and confidence in the detection and management of maternal mental health problems. My heightened interest and enhanced knowledge of the topic ultimately led to my appointment as a nurse consultant and my continuing efforts to explore ways of improving the support provided to mothers with mental health problems, and their families. This means that I have supported mothers and their families across the continuum of mental health need and am aware of some of the contextual factors that influence how mothers with mental health problems are perceived and treated by different professionals and services.

Whilst I do think that HVs have a fundamental part to play in promoting maternal mental health, I am not sure if other HVs concur with my views. My own experience of delivering LVs made me wonder how other HVs felt about LVs and whether there was any sense of a consistent, standardised approach to their purpose and delivery, or indeed, if there needed to be. If HVs were not delivering LVs, I was interested to know whether they were doing something else instead, or preferred to delegate the management of maternal MHPs to an alternative provider.

As a prelude to formulating my research questions I attended a 2-day training on the assessment and management of perinatal MHPs developed by the iHV. I was struck by the small proportion of the time (half a day) that was allocated to 'how to' deliver LVs. The purpose of the training was to train trainers who would then cascade what they had learnt to their health visiting colleagues. I subsequently attended a training session delivered by one of these trainers and discovered that, as the 2-day training had been condensed into 1 day, that the training in LVs had been commuted to a leaflet that HVs would receive post-attendance at the training.

It is impossible for me to be an objective, disinterested researcher. My interpretations are influenced by who I am, all that I know, and all that I have experienced. As McAffery et al (2012 p.217) state 'We recognize where we stand in part through our understandings of where we have come from; this recognition also enables us to begin to shape possibilities towards the future'. As a hermeneutic researcher I am willing to consider the inadequacies of my opinions and to be open to discover new and useful possibilities. In recognition of the fact that neither knowledge or truth are static, I am also aware that there is no one absolute 'truth' waiting to be discovered or exposed.

Gadamer appropriated the notion of truth as 'aletheia' from Heidegger (his teacher). 'Aletheia' is the Greek word to explain the act of concealment and un-concealment that can be interpreted as becoming 'aware of something that was not there, as being there' **(MOULES ET AL, 2014 P.5)**. As has already been stated, awareness is enhanced by pre-existing knowledge, focussed attention and deliberate exploration through dialogic interaction with the views and experiences of others. Hermeneutic research is thus enriched by researchers who have an authentic interest in a topic, an appreciation of the finitude of understanding, an open-ness to the discovery of the complexities of lived experience, and a determination to uncover further possible meanings to existing presuppositions.

1.7. Rigour, validity and ethics

In hermeneutics, analysis is synonymous with interpretation that, in turn, is allied to a rigourous process of thinking. Rigour is important in all types of research. Moules et al (2015) point out that one of the dictionary definitions of rigour is 'the quality of being extremely thorough and careful'. In hermeneutic research this equates to taking 'care' to 'fully' record and explain the decisions taken **(MOULES ET AL, 2015)**. Rigour also implies the acquisition and application of relevant knowledge and skills to ensure 'thorough and careful' conduct throughout the research process. As well as receiving specific guidance on the use of Qualtrics to inform the design and distribution of electronic surveys, I attended internal, external and online training in qualitative and quantitative research methods. I also attended summer schools run by the European Academy of Nursing Sciences over three consecutive years to explore research methods that are appropriate for use in the investigation of complex interventions. Reflexivity also contributes to rigour. Throughout the research process I have endeavoured to consider how my personal 'prejudices' might have influenced decisions taken **(MOULES, 2002)**.

In terms of validity, McCaffery et al (2012) suggest that there is a social and ethical obligation of the researcher to ensure that 'the topic has relevance and at least a reasonable chance of providing something useful in the end to people in need of nursing care` (p.220). This reflects Sandelowski's (1986) reference to the importance of transferability, rather than generalisability, and the expectation that research findings should be applicable to contexts outside the study situation, and should be seen as meaningful and applicable by the intended audience.

Some of the points already made are reflected in the six key ethical principles identified in the Economic and Social Research Council (ESRC) framework for research ethics (Table 1.1).

TABLE 1.1 ECONOMIC AND SOCIAL RESEARCH COUNCIL FRAMEWORK FOR RESEARCH ETHICS: ETHICAL PRINICIPLES

Research should aim to maximise benefit for individuals and society and minimise risk and harm
The rights and dignity of individuals and groups should be respected
Wherever possible, participation should be voluntary and appropriately informed
Research should be conducted with integrity and transparency
Lines of responsibility and accountability should be clearly defined
Independence of research should be maintained and where conflicts of interest cannot be avoided they should be made explicit

In the phases of research involving engagement with HVs I provided clear and full information to participants about the purpose of the research; what their participation would involve; their freedom to ask questions or withdraw at any time; how their anonymity would be protected; and how the data arising from their participation would be analysed, securely stored and reported. All participants affirmed their consent to participate in the study, were advised of the expected timeline of the research, and were invited to contact me, my Director of Studies or the Chair of the ethics committee if they were concerned about any aspect of the research or wished to find out the results of the study. Participation information sheets included statements indicating that there would be no personal benefit to the HVs of taking part but it was hoped that the intelligence gained would help to generate a better understanding of the HVs role in supporting mothers with MHPs in the future. Ethics approval was secured from the University departmental ethics committee prior to the involvement of participants in any stage of the research.

1.8. The research questions

The omission of LVs from the NICE guideline was the starting point for thinking about the role of the HV in supporting mothers with MHPs. Philosophical hermeneutics maintains that at the beginning of a study it is not possible to know all that there is to know or all that it might be useful to know. Rather than being constrained by the limitations of a highly specified research question, it is preferable to start with one or two questions and add more questions as the topic is explored and the research progresses. The primary questions, along with subsequent questions that emerged, are presented in Table 1.2.

TABLE 1.2: RESEARCH QUESTIONS

PRIMARY RESEARCH QUESTION	SECONDARY RESEARCH QUESTIONS	TERTIARY RESEARCH QUESTIONS
Why were LVs not included as one of the recommended evidence-based interventions in the updated NICE guideline for antenatal and postnatal mental health?	What is the quality of the evidence that led to the omission of LVs from the NICE guideline?	How have the changes in the NICE guideline affected what HVs do to support mothers with MHPs?
What are LVs, why do we need them and how do they work?	How, when and why were LVs introduced? What are MHPs and what do we know about their aetiology, prevalence and impact?	How and why have LVs changed since their inception? Are LVs effective? Are LV acceptable to mothers?
Are HVs offering LVs? Do HVs offer support to mothers with MHPs? Do HVs think that supporting mothers with MHPs is compatible with the role of the HV?	What do HVs think about LVs? When do they offer them? Is there a consistent, standardised approach? If HVs continue to offer LVs, what additional components could be added to LVs to make them more responsive and effective?	What do mothers want from health professionals to help them manage their MHPs?
What should HVs be doing to support mothers with MHPs?	What are the barriers and enablers that influence the support that HVs are able to provide to mothers with MHPs?	What are the core components and key clinical activities of effective, acceptable and feasible interventions delivered by non-mental health specialists to mothers in the community?

A survey of HVs was conducted in an early stage of the PhD study to find out how HVs were supporting mothers with MHPs, the factors that influenced their practice, and what they would like to be doing in the future. One of the frequent requests made by survey respondents was for an up-dated, standardised, evidence-based, manual to inform HV perinatal mental health practice. This request is compatible with recommendation 1.7.2. in the NICE guideline for antenatal and postnatal mental health **(NICE, 2014A)** which states that 'Psychological and psychosocial interventions should be based on the relevant treatment manual(s), which should guide the structure and duration of the intervention'. It was therefore considered appropriate to extend the PhD study to explore the possibility of adapting LVs or developing an alternative intervention, if that seemed more appropriate, and then considering the options for transposing components of the proposed intervention into a manualised format. Additional research questions were added to the list (Table 1.3).

TABLE 1.3: ADDITIONAL RESEARCH QUESTIONS

PRIMARY QUESTIONS	SECONDARY QUESTIONS	TERTIARY QUESTIONS
What should be included in the manual?	What is the process for selecting the core components and key clinical activities that could be included in a manual for HVs?	What is included in other manuals delivered by comparable health professionals to a similar target audience?
	Is it possible to integrate evidence from research with evidence from practice and lived experience?	

1.9. Aims and objectives of the research

The research questions were used to inform the aims and objectives of the study and the design of the research.

Aim 1: To establish the implications for HV perinatal mental health practice of the exclusion of LVs from the updated NICE guideline.

Objectives:

- To critically appraise the evidence that led to the exclusion of LVs from the guideline;
- To explore what is meant by LVs, including the definition used in the NICE guideline;
- To consider why LVs were introduced and determine whether they are still needed;
- To discover whether the definition used in the guideline is an accurate reflection of current practice;
- To summarise the factors that influence how NICE guideline recommendations are incorporated into policy and practice.

Aim 2: To clarify the role of the HV in supporting mothers with MHPs, especially with regard to their perceptions and delivery of LVs.

Objectives:

- To ascertain whether HVs believe that supporting mothers with MHPs should be an integral part of their role.
- To establish whether HVs are delivering LVs;
- To ascertain what HVs think about LVs;
- To describe the factors that enhance or compromise the capacity of HVs to identify and support mothers with MHPs;
- To describe the current beliefs, attitudes and practice of HVs with regard to how they understand, organize and deliver the support they provide to mothers with MHPs, whether or not this support is described as LVs;
- To describe the core components that HVs think should form the basis of a health visitor-led intervention;
- To explore what HVs believe is needed to enable them to provide effective support to mothers with MHPs.

Aim 3: To update the LV intervention offered by HVs based on evidence of feasibility, acceptability and effectiveness.

Objectives:

- To identify the core components and key implementation processes of interventions delivered by non-mental health professionals to community-based mothers with MHPs;
- To extract the commonly occurring core components and key clinical activities of effective, feasible and acceptable perinatal mental health interventions from literature reviews of interventions (effectiveness), the views of health professionals (feasibility) and the views of women (acceptability);
- To present the potential components and clinical activities derived from the literature reviews and survey of HVs to a group of expert health visitors, in order to seek consensus regarding the components that should be included in a health visitor-led intervention;
- To produce a draft manual to guide health visiting perinatal mental health practice.

1.10. Research design

Health and social care research can be defined 'as the attempt to derive generalisable or transferable new knowledge to answer or refine relevant questions, with scientifically sound methods' **(HEALTH RESEARCH AUTHORITY, 2017 P.5)**. In complex systems this is not a straightforward process as there are often emergent, unpredictable, non-linear associations between actions and outcomes **(MOORE ET AL, 2019)**. Complexity is manifest in both the health system and the clinical encounter. Clinicians are operating amongst the shifting sands of changing priorities, new technologies and organisational upheaval **(PLSEK & GREENHALGH, 2001)**. Clinicians have to integrate diverse forms of practical and theoretical knowledge and respond with flexibility and compassion to the unique comorbidities, personalities, communication styles, needs, preferences and living arrangements of individuals **(PAWSON, 2010, SMITH BATTLE ET AL, 2013)**.

The support that HVs provide to mothers with MHPs, whether or not it is called LVs, constitutes a complex intervention. Visiting mothers in their own homes confers a degree of uncertainty as HVs never quite know what they might find, or what information might be shared. When offering a mental health intervention, further complexity arises from the challenges of exploring sensitive topics, distressing

feelings and intrusive thoughts; responding to cultural diversity and alternative explanatory models of illness; assessing need, resilience and risk; considering the interactions between, and well-being of, all members of the family; and then offering effective strategies that are compatible with maternal expectations, preferences and circumstances. Social complexity arises from the complex network of interactions between parents and others, HVs and parents, HVs and colleagues, HVs and their managers, and HVs and other professionals who may be involved in the provision of collaborative or integrated care **(HAWES ET AL, 2009)**. Complexity is also generated by variations in contextual factors that can include guidelines, protocols, commissioning priorities, workforce capacity, organisational priorities, managerial support, professional autonomy and physical space and distance **(MOORE ET AL, 2019**).

Greenhalgh and Papoutsi (2018) propose that conventional, linear research designs are not appropriate for complex interventions delivered in complex systems. Rather than seeking to strip away the confounding variables or contextual background noise, in pursuit of an elusive 'truth' about 'what works', greater insight can be gained from combining different kinds of data from multiple sources to find out 'what works in practice'. This is the essence of hermeneutic enquiry – to not only demonstrate a comprehensive examination of a topic from multiple perspectives but also to perceive multiple forms of data in new and untraditional ways that stimulate a greater breadth and depth of understanding **(MOULES, 2002; VANDERMAUSE, 2008)**. Every stage involves reflexivity and decision-making from the researcher. The methods that are required to expand one's personal horizon by fusing that horizon with the horizons of others are not always obvious at the start of a research project. Gadamer maintained that the most appropriate methods will be revealed as the process of inquiry unfolds and different avenues of understanding are exposed **(AGREY, 2014)**. Hence the addition of a further phase of research to develop a manual to guide HV perinatal mental health practice.

Philosophical hermeneutics shares similarities with pragmatism in the assumption that our understanding of the world is inherently limited by our interpretations of our experiences **(MORGAN, 2014)**. Although a group of researchers or professionals with equivalent training and experience may share similar views, each individual will still have their own unique viewpoint. It is this uniqueness that will determine the questions that the individual researcher thinks need answering, and the methodology and research methods that seem appropriate **(MORGAN, 2007)**. Pragmatism is derived from the Greek word 'pragma' which means action. Choice of action is based on prior knowledge and beliefs about the expected consequences of a particular action. The outcomes of actions taken predict future actions. This may lead to repetitions of successful actions or to consideration of alternative actions if the previous actions did not culminate in the desired outcomes. Dewey, one of the founding fathers of the concept of pragmatism, held that the primary purpose of inquiry was to 'create knowledge in the interest of change and improvement' **(KAUSHIK & WEBB, 2019 P.5)**. Pragmatism is an orientation towards solving practical problems in the real world. Before new knowledge can be created, and alternative actions selected, the problem has to be clearly defined in order to make decisions about the purpose of the inquiry/goals of the research. Pragmatism also relates to the consideration of the relative merits of using different research methods (actions) to both explore what is already known and generate new ideas about what might be possible **(MORGAN, 2007)**. Research methods are therefore chosen to to respond to the questions that have been posed, although both the question and the choice of method may be amended as new insights are gained and a greater depth of understanding is achieved. A mixed methods approach is therefore required to explore multiple perspectives and generate insightful solutions to the issues identified.

There is some debate about the definition of mixed methods research. The definition used to inform this study is the one proposed by Thurston et al (2008. p.3) 'Mixed methods studies can either combine methods from different paradigms or use multiple methods within the same paradigm, or multiple strategies within methods'. Mixed methods implies the use of both quantitative and qualitative data to answer research questions. The 'point of interface', where mixing occurs depends on the design of the study **(MORSE & NIEHAUS, 2009 P.5)**. 'Mixing' can take place during data collection, data analysis or data interpretation. Green et al (1989) propose 5 reasons for using a mixed methods design (Table 1.4).

TABLE 1.4. REASONS FOR USING A MIXED METHODS DESIGN (GREEN ET AL, 1989)

Triangulation: corroboration of results from different methods
Complementarity: enhancement or clarification of the results from one method with the result of another method
Development: the results of one method help to develop or inform the other method
Initiation: recasting of questions or results from one method with questions or results from another method
Expansion: extends the breadth and range of inquiry by using different methods

All these reasons are relevant to a greater or lesser extent with regard to the reasons for using mixed methods in this study. This research employs a multi-phase, emergent, mixed methods design whereby secondary research methods are introduced to build on the primary method **(CRESSWELL & PLANO CLARK, 2011)**.

Given the need for both transparency and a systematic approach to research design, especially when mixed methods are involved, it is recommended that one or more theoretical frameworks should be used to inform the different phases of the research. As it has been established that LVs constitute a complex intervention, it seemed logical to explore the utility of the MRC guidance for developing and evaluating complex interventions as an appropriate framework for the study. The 2000 version of the MRC guidance was updated in 2008 **(CRAIG ET AL, 2008)**. Changes in the updated guidance included the need for researchers to allocate more time and resources to the development and evaluation phases of research; to deploy a less linear process for evaluation; to integrate process and outcome evaluation; to provide a theoretical explanation of the mechanisms of change; and to acknowledge the benefits of tailoring interventions to context **(CRAIG ET AL, 2008)**. In 2018, Bleijenberg et al proposed that more time and attention should be allocated to the development phase of the MRC guidance to ensure that interventions are transferable to the practice setting and more likely to be successful.

The enriched development phase of the MRC guidance produced by Bleijenberg et al (2018) (Table 1.5) was therefore used to provide a practical, systematic, framework to explain the research process and facilitate presentation of the research findings in a logical sequence. The research process has involved contemporaneous, iterative, and dynamic activities, so the sequence of the presentation of the results does not necessarily reflect the order in which the research was conducted. Each of the stages of the Bleijenberg et al framework are replicated as Chapter headings to ensure that the constituent elements are adequately addressed. A more comprehensive description of each of the stages of intervention development will be provided in Chapter 2 in order to explicate the relationship between the philosophical assumptions, the selected research methods and the stages of the framework.

TABLE 1.5. STAGES OF THE ENRICHED DEVELOPMENT PHASE OF THE MRC GUIDANCE FOR COMPLEX INTERVENTIONS (BLEIJENBERG ET AL, 2018)

STAGES OF THE ENRICHED DEVELOPMENT PHASE OF THE MRC GUIDANCE	THESIS CHAPTER
Problem Identification and Definition	3
Systematically Identifying the evidence base	4
Identifying or developing theory	5
Determining the needs of providers and recipients	6
Examining current practice and context	7
Modelling process and outcomes	8
Intervention design	9

1.11. Outline of the thesis

In this chapter I have provided an overview of my rationale for undertaking this PhD study and the philosophical assumptions and theoretical framework guiding the design of the study.

This thesis does not follow a conventional format. Each chapter reveals a separate process of data collection and interpretation that uncovers new understanding. The philosophical assumptions that are allied to Gadamerian hermeneutics run as a discernible thread within and between every chapter. In the context of the hermeneutic circle, the constant dialogue between the interpretation of the constituent parts, conscious awareness of what has gone before, and the expectation of an imagined whole, has the potential to expose contradictory inconsistencies between a researcher's pre-understandings and emergent possibilities **(AGREY, 2014)**. Gadamerian hermeneutics implies that appraisal of new discoveries from literature or research, in the light of my own historicity, is therefore as meaningful and valid as systematic appraisal by other methods.

The findings emerging from each chapter are presented in the context of the expectation of the whole (the prototype guide for practice) whilst the meaning of the whole is understood by appreciating the synergising influence of the constituent parts. The method, results, discussion and conclusions for each phase of the research are presented in each chapter to create a cohesive narrative both within each chapter and between chapters.

The philosophical orientation of Gadamerian hermeneutics informed the decision not to include a chapter dedicated to a conventional literature review. A hermeneutic literature review was undertaken with the intention to deepen understanding, rather than to synthesise data or provide a conceptual analysis of the text **(GREENHALGH ET AL, 2017; KINSELLA, 2006)**. Smythe & Spence (2012) argue that re-viewing literature should be repeatedly re-viewed and reflected on, and incorporated into, every stage of the research process. A static stand-alone chapter at the beginning of a thesis does not reflect the dynamic nature of knowledge or the ebb and flow of understanding as the researcher knows more, but also realises how much more there is to know.

The reason for taking a more liberal approach is the perceived limitations of a traditional literature review. In a comparison of search methods used to identify relevant literature, Greenhalgh and Peacock (2005) concluded that strategies such as citation tracking, pursuing references that look interesting and 'simply

being alert to serendipitous discovery'…'may have a better yield per hour spent and are likely to identify important sources that would otherwise be missed' (p.1065). According to Greenhalgh and Peacock (2005) only 25% of literature relevant to their study was found using conventional search methods of 15 different databases. Boell & Cezec-Kecmanovic (2011 p.11), in their article describing how to conduct a hermeneutic review, suggest that the deliberately narrow focus of a more systematic approach 'limits the intellectual horizon of research' and 'discourages curiosity about alternative perspectives'.

Rigourous, clearly specified, search methods often culminate in the identification of a large cache of articles, the majority of which are then excluded based on superficial examination of limited information, such as that derived from the title and the abstract. In a review evaluating perinatal mental health interventions, 1898 articles were retrieved from 5 databases but only 4 articles remained after the application of inclusion/exclusion/appraisal criteria **(LAVENDER ET AL, 2016)**. There is often no comprehensive explanation to justify why the majority of the studies identified in the initial search have been excluded. Rigourous quality appraisal limits the number of articles included in the final analysis. As an example, Morrell et al (2016) conducted a systematic review, evidence synthesis and meta-analysis evaluating the clinical effectiveness, the cost-effectiveness, safety and acceptability of interventions to prevent postnatal depression. There were 19 people in the review team. Eighty-six trials and forty-four studies were included in the analysis. The results of this extensive and comprehensive 458 page review were inconclusive.

Without prior knowledge of the meaning behind the words that are used to describe interventions relevant articles may be excluded, or inappropriate studies may be included. The NICE review team responsible for reviewing the evidence regarding the effectiveness of LVs based their meta-analysis on five studies. The study with the largest number of participants was not a study that included an intervention purposefully designed to treat maternal MHPs, although the intervention was described as LVs **(WIGGINS ET AL, 2005)**.

Inappropriate application of 'method' can obscure and distort the truth. Gadamer states that 'Applying the method is what the person does who never finds out anything new, who never brings to light an interpretation that has revelatory power.' **(GADAMER, 2001, P.41 - 42)**. 'Scientific enquiry is always guided by more prejudice than can be kept in check by any method: for example , in the selection of research questions, in hypothesis formation, and in any number of metaphysical (or other) assumptions tacitly or unconsciously used to characterize objects of inquiry' **(GEORGE, 2020, SECTION 4.3)**. Understanding emerges from an interpretation of something that the interpreter believes to be true and, as such, should be considered as a valid interpretation. In an analysis of different types of review Greenhalgh et al (2018) suggest that 'While there are occasions when a systematic review is the ideal approach to answering specific types of question, the absence of thoughtful, interpretive critical reflection can render such products hollow, misleading and potentially harmful' **(GREENHALGH ET AL. 2018 P.3)**.

A starting point for a systematic hermeneutic literature is described in Chapter 2 (Methodology) with reference to how the iterative cycles of discovery and interpretation help to identify relevant articles that can be used in subsequent stages of the research. Pertinent findings are included in specific chapters when the content resonates with the focus of the chapter or are used as the foundation of a more structured approach to selection of appropriate articles. The rationale for the way that the literature is selected and interpreted is explained in the method section of each chapter. When there is a very specific requirement for a more focussed and explicit search of the literature, such as the rapid review described in Chapter 4 (examining the evidence), conventional search techniques are used.

Chapter 2 revisits, and expands on, the philosophical assumptions introduced in this chapter that in turn guide the methodological principles that underpin the choice of research methods. The research methods are briefly explained in Chapter 2 with reference to how they fit with each stage of the enriched development phase of the MRC guidance for complex interventions **(BLEIJENBERG ET AL, 2018)**.

Chapter 3 focuses on 'identifying and operationalizing' the nature of the problem **(BLEIJENBERG ET AL, 2018. P.88)** to expose the complexity of definition, aetiology, assessment, impact and context that complicate the delivery of appropriate perinatal mental health interventions.

Having identified the scale and impact of the problem, the logical next step is to think about how to solve it. This process began with identifying established interventions of proven effectiveness. The method and findings from a rapid review of effective interventions to treat community based mothers with mental health problems, delivered by non-mental health specialists, is described in Chapter 4. The challenge then is to ascertain the particular characteristics of interventions that contribute to their effectiveness. Chapter 4 includes an explanation of how Chorpita et al's (2005) distillation and matching model has been used to guide the extraction and tabulation of the commonly occurring core components of the 20 effective interventions identified by the rapid review. Key implementation processes, as defined by Singla et al (2017), for each of the effective interventions, are also highlighted.

To address the suggestion that active components of interventions are not always obvious or possible to measure, the MRC guidance advocates the use of theory to explain how the problem is created and sustained and to provide the rationale for how and why an intervention is supposed to work **(CRAIG ET AL, 2008)**. Chapter 5 explains the method and findings of a literature review to identify theories that might help to inform or explain the mechanisms of action of the intervention components as well as the synergistic influences of context, actors, mechanisms and outcomes **(O'CATHAIN ET AL, 2019)**.

Complex interventions occur in complex social systems and the relevance and effectiveness of interventions is influenced by the attitudes and responses of the intended providers and recipients of the intervention. In Chapter 6, the method and findings from a review of the literature, to determine the needs, perceptions, preferences and capacities of public health nurses/health visitors and mothers, are considered in order to ensure the incorporation of multiple perspectives in the analysis of existing provision and consideration of what should be included in an updated intervention **(YARDLEY ET AL, 2015)**.

An examination of current practice facilitates an accurate description of the intervention (LVs), from the perspective of practising health visitors, as well as the identification of barriers and facilitators that enhance or compromise implementation and proposals for future practice. The method and findings from an on-line survey designed to explore HV perceptions and experience of delivering LVs are presented in Chapter 7.

Modelling process and outcomes is the topic of Chapter 8 achieved through the research activity of a modified, technological, Delphi approach. A commentary in Chapter 9 accompanies an abridged version of the prototype of the guide for practice that represents the tangible end-product of the previous phases of research.

Although an endpoint has been reached in the sense of producing the guide for practice, Gadamer cautions that it is not possible to reach one final objective 'truth', only an interpretation of multiple realities that appears to 'hold true' at one particular moment in time for a particular researcher. Chapter 10 includes a critical reflection and discussion of the research process and outcomes in order to highlight the benefits and limitations of the research as well as the implications for practice and future research.

FIG 1.1. PROVIDES A SUMMARY OF RESEARCH STAGES AND METHODS (RIGHT)

1.12. Chapter summary

This chapter has explained the importance of identifying and supporting mothers who may be more vulnerable to experiencing any form of psychological distress in the perinatal period, not only because of the potentially lasting impact on the mother but also because of the range of adverse consequences that may affect the health, growth, development and safety of her baby. Health visitors have been identified as a relevant health professional to provide additional support because of their universal access to all families during pregnancy and the first postnatal year. The potential of HVs to play a key role in identifying the hidden 50% of mothers who are not being identified and not getting the help they need has also been noted. The dilemma arising from the exclusion of LVs from the NICE guideline has been highlighted as a catalyst for change and the stimulus for the subsequent investigation of LVs. Gadamerian hermeneutics had been introduced to explain the philosophical assumptions that guide the research process and emphasises the need to remain explicitly mindful of the influence of personal and professional experience on interpretations and outcomes. The enriched development phase of the MRC guidance is introduced as the framework that informs the stages of research and the rationale for the way that the research is presented in subsequent chapters.

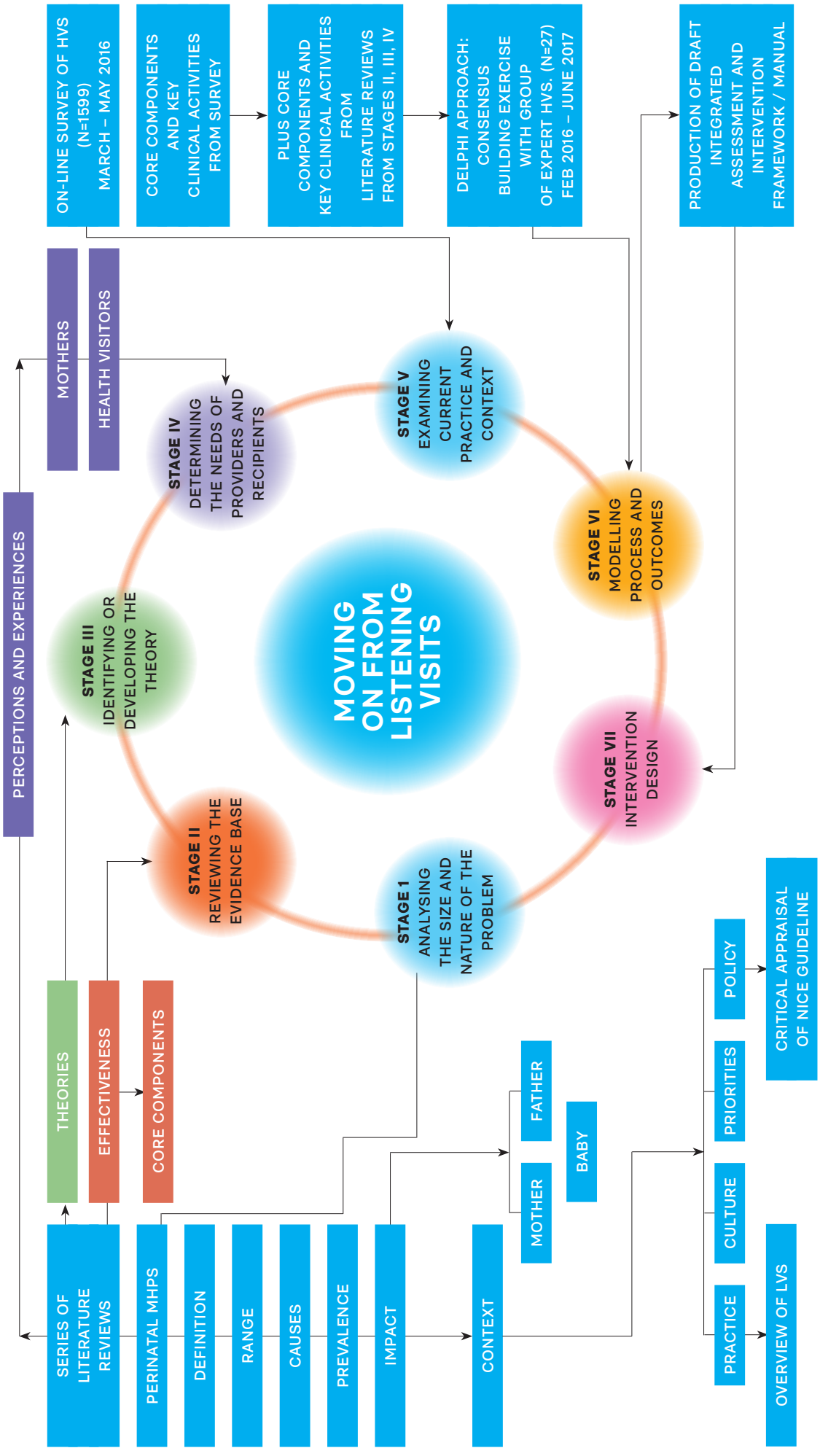


FIG 1.1 SUMMARY OF RESEARCH STAGES AND METHODS

Chapter 2. Methodology and Methods

2.1. Introduction

Koch (1996) asserts that methodology 'describes the process by which insights about the world and the human condition are generated, interpreted and communicated' (p. 174). This chapter builds on the philosophical assumptions and research paradigms introduced in chapter 1 to explain the methodological principles that inform the research methods that have been used to investigate the research questions posed in relation to the topic of LVs. The methodological principles are based on a worldview informed by philosophical hermeneutics, pragmatism and complexity theory **(GREENHALGH & PAPOUTSI, 2018; KAUSHIK & WALSH, 2017; MOULES, 2002)**. The non-specific strategies that emerge from the philosophical assumptions and methodological principles associated with these paradigms need to be translated into practical actions/research methods. This chapter describes how this is done using the stages of the enriched development phase of the MRC guidance to provide a framework to guide the process **(BLEIJENBERG ET AL, 2018)**.

2.2. Philosophical assumptions

The essential tenets of philosophical hermeneutics have been described in chapter 1. The generalised procedures associated with philosophical hermeneutic research include the address, the collection of data and interpretive analysis of the topic **(MOULES, 2002)** Pragmatism and complexity theory are complementary paradigms to Gadamerian hermeneutics. Pragmatists reflect on 'the nature of the problem and its potential solutions, and on the nature of the potential solutions and the likely actions' **(KAUSHIK & WALSH, 2019 P.8)**. Pragmatists subscribe to the view that understanding is achieved by using multiple modes of inquiry including observations, experience and experiments **(KAUSHIK & WALSH, 2019)**. A pragmatist approach involves critically evaluating the strengths, limitations and relevance to practice of multiple types of evidence.

The philosophical assumptions underpinning complexity theory suggest that rationalist, reductionist research methods, that may help to expose the effectiveness of unimodal solutions for specific health problems in clearly defined populations, do not reflect the reality of healthcare organisations, systems, encounters or interventions **(GREENHALGH & PAPOUTSI, 2018)**. Complexity theory posits that the world is composed of complex systems that are constantly evolving. Mowles (2014) maintains that interactions between individuals are 'predictably unpredictable' because there are so many factors that might influence behaviour and interactions. This applies to actors within a system (health professionals, patients, commissioners) as well as those investigating how the system works (researchers).

It may not be possible to identify all the factors that have the potential to influence outcomes. The constituent parts of an intervention presumed to exert a beneficial effect may not be the parts that exert the greatest impact or may only be effective when combined with other parts of the intervention or system **(CLARK ET AL, 2012)**. Sensitive dependence on initial conditions is a key concept of chaos theory, which in turn is a defining property of systems theory. According to this theory it may be relatively small changes that can make the biggest difference. These small changes may, or may not, be identified by both deliberate and serendipitous inquiries and may be more or less significant in different contexts.

The point is that Gadamerian hermeneutics, pragmatism and complexity science all acknowledge the existence and unpredictability of multiple influences, multiple perspectives, multiple outcomes and, potentially conflicting interpretations, of the factors affecting the effectiveness, feasibility and acceptability of interventions, and the options, opportunities, barriers and catalysts for change **(PAPOUTSI ET AL, 2021)**. Multiple research methods are therefore required to gain a deeper understanding of the

issues that have been identified and some possible answers to the questions that have been posed. The theoretical framework of the enriched development phase of the MRC guidance developed by Bleijenberg et al (2018) is used to make the investigative and interpretive process more manageable. (see table 1.5 on page 27). The stages of the framework, their relevance to this study and the research methods that have been used in each stage, are described in the rest of this chapter.

2.3. Research methods

This section describes the rationale for the choice of research methods. An overview of the steps that were taken is provided. More detailed descriptions of methods used are included in subsequent chapters so that each stage of the process can be viewed and interpreted as a study within a study, but also as a constituent part of the overall thesis.

2.3.1. Problem identification and definition

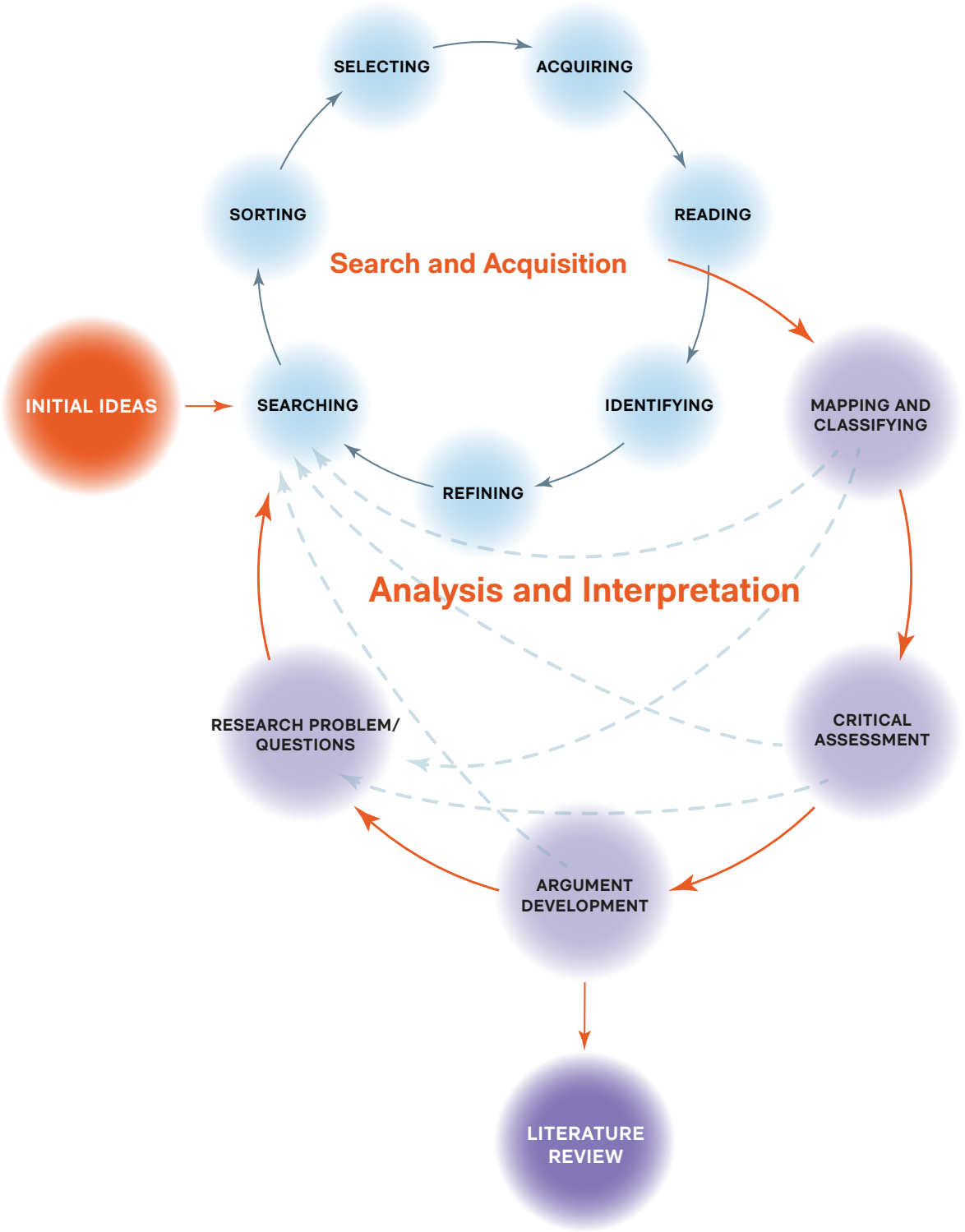
The first stage in the research process is to identify and operationalise the nature of the problem **(BLEIJENBERG ET AL, 2018)**. This relates to the nature of the problem that requires the intervention, problems with identifying and delivering appropriate solutions to solve the problem, the problem with the intervention under study and problems with the context for delivery that will determine how the intervention is implemented.

The first part of the problem to be addressed was to understand why LVs were omitted from the updated NICE guideline (NICE 2014A) as a recommended intervention for mothers with mild to moderate perinatal depression. (2014a). This required an examination of the evidence used by NICE to inform their decision. In order to interpret the evidence a more comprehensive understanding of what LVs are, why they were introduced, any adaptations that have occurred, whether the need for them has changed, and ultimately whether they are still fit for purpose, was needed. Chambers and Norton (2016, p.3) suggest that it is inevitable that 'new, better and more cost-effective interventions' will be developed that will replace existing evidence-based practice, so it is also important to consider the comparative relevance and effectiveness of alternative interventions. The relative merits of the intervention suggested by NICE as an alternative to LVs will also be considered. Healthcare interventions, including LVs, are developed to respond to a particular health problem. To determine whether LVs are fit for purpose it was essential to ascertain the nature of the problem that they are meant to treat and the outcomes that are expected. This requires an exposition of what is known about the aetiology, prevalence and impact of perinatal MHPs.

Following a critical appraisal of the evidence informing the recommendations in the NICE guideline, a systematic hermeneutic literature review was initiated to find out more about LVs. This method involves a repetitive, cyclical process of accessing and interpreting all relevant sources of information **(BOELL & CECEZ-KECMANOVIC, 2014)**. (see Fig. 2.1)

Greenhalgh (2016) suggests that a hermeneutic systematic review has an intellectual affinity with 'Critical Interpretive Synthesis' **(DIXON-WOODS ET AL, 2006)**. The information retrieval method used in this review is similar to 'Cluster Searching' whereby kinship studies, sibling papers and study clusters relating to a seminal article are identified **(BOOTH ET AL, 2013)**. There are also elements of a hermeneutic systematic review that are comparable to elements in mapping reviews, scoping reviews and focused mapping and scoping reviews **(ARKSEY & O'MALLEY 2005; BRADBURY-JONES ET AL, 2019; PERRYMAN, 2016)**. This serves to illustrate the multitude of approaches to conducting literature reviews that have been variously described as a 'meta-madness' and a 'meta-muddle' **(AVEYARD & BRADBURY-JONES, 2019; THORNE, 2017)**.

FIG 2.1. HERMENEUTIC FRAMEWORK FOR THE LITERATURE REVIEW PROCESS CONSISTING OF TWO MAJOR HERMENEUTIC CIRCLES



Reproduced with permission from Boell & Cecez-Kecmanovic, 2014

Although all reviews should follow a clearly described process, Gadamer maintains that even the most prescriptive methods are influenced by researcher prejudgments and that an emphasis on reproducibility conspires against subjective interpretation, serendipitous discovery and an expanded understanding of the topic. Sutton et al (2019) maintain that whatever approach is chosen, either from the 48 review types listed in their article, or new ones that are being developed, all reviewers should be reflexive about the implications of their relationship to their review.

The starting point for the hermeneutic review is described in this chapter because it provides the springboard for the generation of the articles that can then be used as the foundation for subsequent reviews. The seminal article heralding the introduction of LVs was published in 1989 **(HOLDEN ET AL, 1989)**. This article was entered into Google scholar as the 'citation pearl'. Any articles written in English following the publication up until the present day (final update completed in 2020), referencing LVs/ interventions delivered by HVs/ public health nurses to mothers with perinatal MHPs, were included, if they added 'meaning' to the review **(GREENHALGH ET AL, 2017)**. Inclusion/exclusion criteria were not applied because of their potential to limit the unknown 'horizons' of the research **(BOELL AND CEZEC-KECMANOVIC, 2011**). At this stage in the review a quality appraisal checklist was not used, as it has been suggested that even methodologically 'weaker' studies, especially in the field of public health, can provide information of value **(PETTICREW, 2015)**.

The advantages of using Google scholar are that a diverse array of source materials, such as 'journal and conference papers, theses and dissertations, academic books, pre-prints, abstracts (and) technical reports' can be accessed **(GOOGLE SCHOLAR, 2017 P.1)**. This may also be a disadvantage due to the possibility of an increased volume of irrelevant subject matter. A comparison of searches for medical literature in Google and Pubmed found that Google articles were more likely to be relevant to the research question, more highly cited, and from journals with higher impact factors than those identified via PubMed **(NOURBAKSH ET AL, 2012)**. It was also noted that a more comprehensive search is achieved by searching more than one database. **(NOURBAKSH ET AL, 2012**).

Titles and abstracts of the 614 articles generated by the google search were reviewed. 165 were excluded on the basis that they were written in another language or were not relevant. (Table 2.1.) The remaining 449 articles were read and categorised according to the main focus of the article. The MeSH terms associated with the 449 articles were used to inform more detailed searches of relevant databases, in order to investigate the specific research questions addressed in subsequent chapters of the thesis. Subsequent searches were also supplemented with reference list checking, forward citation searching and journal email alerts.

TABLE 2.1. RESULTS FROM REVIEW OF TITLE/ABSTRACTS OF REFERENCES CITING 'PEARL' CITATION, IN GOOGLE SCHOLAR (SEARCH ORIGINALLY PERFORMED IN JUNE 2015, UPDATED SEPTEMBER 2020)

MAIN FOCUS OF THE ARTICLE	NUMBER OF ARTICLES (N = 614)
Listening visits/role of the HV in perinatal mental health care	57
Role of the HV (everything except perinatal mental health care)	26
Impact on the child	22
Mother-infant relationships/interaction	12
Prevalence, aetiology, symptoms	78
Prevention	19
Assessment	31
Treatments/Interventions (not delivered by HV)	152
Pathways/collaborative care	12
Views of women	33
Views of health professionals	7
Excluded	165

Details of how a continuing hermeneutic investigation of the literature helps to elucidate various aspects of the problem are described in Chapter 3.

2.3.2. Systematically Identifying the evidence base

The MRC guidance for developing and evaluating complex interventions emphasizes the importance of a systematic and comprehensive understanding of what is already known in terms of interventions that have been demonstrated to effectively address the problem identified **(CRAIG ET AL, 2008)**. The problem identified, suggested by the ommission of LVs from the NICE guideline, is that LVs may not be an appropriate intervention to treat mothers with MHPs. The purpose of the review is to search for evidence of effective interventions, delivered by non- mental health specialists (such as health visitors), designed to treat community-based mothers with perinatal MHPs. Systematic reviews can provide a useful starting point for the identification of relevant studies especially when supplemented with a targeted literature search for more recent studies or studies not included in the systematic reviews.

Systematic reviews demand significant time and resources. Petticrew & Roberts (2006) have estimated that systematic reviews take between 216 and 2,518 hours to complete and cost at least $100,000. Robust procedures are not always followed and the conclusions drawn may not be helpful. Key features of systematic reviews are transparency and reproducibility. Even when inclusion/exclusion criteria are clearly defined there are inevitable variations in researcher interpretation and application of these criteria and inherent difficulties in following exactly the same procedure and arriving at exactly the same conclusions **(DELANEY & TAMÁS, 2018)**. Ioannidis (2016) suggests that too many systematic reviews are being produced that are unnecessary, misleading or produce conflicting or inconclusive information.

The purpose of systematic reviews is to aggregate findings from interventions delivered in the same way to similar populations that have been carefully selected to avoid contamination of the intervention and outcome by extraneous variables. This does not reflect the complexity of clinical contexts or patient populations. Even when the quality of the systematic review is assured, 'numerous areas where the evidence is limited or contested' are exposed with the inevitable conclusion that the evidence is equivocal regarding the effectiveness of the specified intervention **(GREENHALGH & MALTERUD, 2017 P.98)**.

Rapid reviews have been introduced as a mechanism for streamlining systematic reviews by simplifying or omitting certain components in order to produce information in a shorter period of time **(KHANGURA ET AL, 2012)**. Streamlined methods include reviewing only published literature, limiting the number of databases searched, making exclusion criteria more exclusive, limiting the number of people involved, not conducting a quality appraisal and presenting the results as a narrative summary **(TRICCO ET AL, 2016)**. A rapid review of rapid review methodologies published in 2016 suggested that there was no evidence to suggest that rapid reviews should not be done or that the results achieved are misleading **(HABY ET AL, 2016)**. Langlois et al (2019 p.1) state that 'Rapid reviews have emerged as an efficient approach to producing relevant and contextualised evidence'. A practical guide for conducting rapid reviews was produced by the World Health Organisation in 2017 **(TRICCO ET AL, 2017)**. For the above reasons a rapid review is the chosen method used to identify effective interventions, delivered by non-mental health specialists, to community-based mothers with MHPs. This was considered an appropriate method given that this is just one of a series of reviews designed to generate understanding about the past, present and future role of HVs in supporting mothers with MHPs. The method and the findings are presented in Chapter 4.

Once it has been established that an intervention works, it is useful to know why it works so that it can be more easily replicated. It is not always possible to ascertain from RCTs or systematic reviews the components of effective interventions that are most likely to confer benefit. The core components of an intervention refer to the essential functions, or principles, and associated elements and intervention activities that are judged necessary to produce the desired outcomes **(BLASE & FIXSEN, 2013)**. Core components include the content of the intervention, the capacity and confidence of the practitioners required to deliver the intervention and the structure and culture of the organization that supports or hinders the delivery of the intervention **(BLASE & FIXSEN, 2013)**. Singla et al (2017) in their systematic review of effective interventions for community-based adults with MHPs suggest that key implementation processes should also be considered as core components, as these have the potential to impede or enhance the effectiveness of an intervention.

Core components of effective interventions are not always clearly described making it difficult to know what needs to be replicated in order to achieve the same results **(HOFFMAN ET AL, 2014)**. In complex interventions this is particularly challenging because it is often the synergistic effect of multiple components that make the difference. Some of those components, such as aspects of the therapeutic relationship, may be difficult to measure and quantify **(SUTCLIFFE ET AL. 2015)**. If the intervention is not clearly specified it is harder to design a training programme or specify the expected outcomes. There is a possibility that those whom the intervention is intended to help might be harmed by inept applications of treatments, negative attitudes or poor combination of treatment technique and patient problem **(LAMBERT, 2013)**. For example, without proper training, LVs risk perpetuating maternal ruminatory thinking, potentially exacerbating the severity of depression and compromising maternal sensitivity **(DEJONG, FOX AND STEIN, 2016; TESTER-JONES ET AL, 2016)**.

Various methods have been suggested to enable the identification of the core components of effective interventions, to inform the design of new interventions or adaptations of existing interventions to suit the needs of different client groups and/or the availability of staff or resources. These include the distillation and matching model **(CHORPITA ET AL, 2005)**; ADAPT-ITT **(WINGWOOD AND DICLEMENTE, 2008)**; M-PACE **(CHEN ET AL, 2013)**; Intervention Components Analysis **(SUTCLIFFE ET AL, 2015)**; an integrated approach to intervention planning **(BAND ET AL, 2017)**; Common Components Analysis **(MORGAN ET AL, 2018)**; and FNP-ADAPT **(DARTINGTON SERVICE DESIGN LAB & FAMILY NURSE PARTNERSHIP NATIONAL UNIT, 2018)**. The guiding principle underpinning all these methods is the assumption that effective interventions share 'a detectable set of common components within a specific topic area that can be distilled' **(CZYMONIEWICZ-KLIPPEL ET AL, 2018 P.167)** and that interrogation of the common factors, elements or components of interventions provides insight into 'what works for whom and under which conditions'**(KAYE ET AL, 2018 P.96)**. The method used for identifying the core components/ active ingredients of effective interventions in this thesis is based on the distillation and matching model (DMM) **(CHORPITAL ET AL, 2005)**. A more detailed account of the method and the findings of this process are reported in Chapter 4.

2.3.3. Identifying or developing the theory

A theory is a system of ideas intended to explain something. Theories include formal theories and informal theories arising from experience, ideas, expectations and common sense **(HAWE, 2015; MOORE AND EVANS, 2017)**. The MRC guidance advocates the identification or development of theories to explain how an intervention is supposed to work **(BLEIJENBERG ET AL, 2018)**.

Moore and Evans (2017) maintain that a theory is only useful if it helps to elucidate the actions that are needed to disrupt the mechanisms that cause, perpetuate or sustain a problem. Theories can explain or guide individual behaviours or individual elements of an intervention or can provide a global overview of the actions, events and circumstances that contribute to the process of change that determines the effectiveness of the intervention. A programme theory helps to explain 'the structures, behaviours, processes and contextual features' that are needed, in combination with the recommended components of the intervention, in order for the intervention to work **(DAVIDOFF ET AL, 2015 P.230)**. Segal et al (2012), in their systematic review of home visiting interventions to prevent child maltreatment, found that programmes with a clearly articulated theory-driven approach were more likely to be successful. Davidoff et al (2015 p.228) argue that 'the explicit application of theory could shorten the time needed to develop improvement interventions, optimise their design, identify conditions of context necessary for their success, and enhance learning from those efforts.' Other researchers have challenged the assumption that theory-driven interventions improve outcomes **(DALGETTY, 2019; PRESTWICH ET AL, 2019)**.

The balance of evidence suggests that there is value in exploring the theories that underpin the effectiveness of interventions. The BeHEMoTH mnemonic (Behaviour of Interest; Health context; Exclusions; Models or Theories) developed by Booth and Carroll (2015) has been used to guide the search strategy to identify the theories that might help to inform or explain the causes and consequences of maternal MHPs and the mechanisms of action of components or interventions. The method and the findings of this review are presented in Chapter 5.

2.3.4. Determining the needs of providers and recipients

Even the most effective interventions will not work in the real world of clinical practice if they do not target a problem of perceived importance to both the providers and the recipients of the intervention. The proposed solutions need to be appropriate, acceptable and compatible with the recipient's needs, preferences and circumstances. Both the provider and the recipient must have the motivation and capacity to engage in the intervention and share the belief that the intervention is likely to lead to beneficial outcomes **(BLEIJENBERG ET AL, 2018)**.

Hawe (2015) maintains that failure to acknowledge the relevance of practitioner knowledge in understanding the clinical application of effective interventions may 'blind us to the very mechanisms we seek to understand' (p.307). This need to understand the reality of the 'swampy lowlands' of primary care practice is summed up by Greenhalgh and Papoutsis (2018) who state, 'People use their creativity and generate adaptive solutions that make sense locally. The articulations, workarounds and muddling-through that keep the show on the road are not footnotes in the story, but its central plot. They should be carefully studied and represented in all their richness' (p.2.). West et al (2017) argue that failure to consider practitioner perceptions of the acceptability, appropriateness and feasibility of evidence-based interventions potentially compromises implementation and undermines effectiveness.

Indicators of the acceptability of interventions to patients include non-engagement, non-compliance and premature discontinuation of treatment. Drop-out rates are particularly high for patients receiving treatments for depression **(COOPER & CONKLIN 2015)** and even higher for women with postnatal depression **(O'MAHEN ET AL, 2012)**.

Relevant articles identified in the first cycle of the hermeneutic literature review were used to identify key search terms and additional articles to facilitate an exploration of maternal views of illness, assessment and care and health visitor perceptions and experiences of identifying and supporting mothers with MHPs. In complex interventions, it is inevitable that there will be different perceptions about the active ingredients of interventions and different components that are helpful at different times, in different situations and for different people. The hermeneutic researcher is constantly integrating multiple views and perceptions from multiple sources of data, including apparent discrepancies and contradictions, with what is already known, in order to think differently in the light of new and emerging information **(THIRSK & CLARK, 2017)**. As Moules (2002 p.14) states 'hermeneutics pays attention to the instance, the particular, the event of something that does not require repetition to authenticate it's arrival'. Whilst it might be beneficial to look for themes and commonalities both between participants in qualitative studies and between studies in meta-syntheses of qualitative research, it is often the disconfirming case that provides the greatest insight **(THORNE, 2017)**. A more detailed description of the search strategy and conclusions drawn from the analysis of the retrieved articles are presented in Chapter 6.

2.3.5. Examining current practice

Chambers and Norton (2016) hypothesise that practice-based evidence provides more useful information than that obtained from RCTs and would promote a 'more robust understanding of how to optimise effective interventions over time' **(CHAMBERS & NORTON, 2018)**. An accurate description of current practice is considered to be an essential pre-requisite to the development, adaptation or re-design of interventions **(BLEIJENBERG ET AL, 2018)**. Specific details about intervention timing, dose, frequency, intensity, eligibility and outcomes are necessary to generate an understanding of commonalities and variations in practice.

Barriers and facilitators that compromise or enhance optimal delivery need to be identified as well as the beliefs, expectations, motivation, and competencies of the personnel expected to deliver the intervention **(LIPWORTH ET AL, 2013; BLEIJENBERG ET AL. 2018).**

Surveys of mothers, health professionals and Clinical Commissioning Groups **(BOOTS FAMILY TRUST ALLIANCE 2013, MATERNAL MENTAL HEALTH ALLIANCE 2014, KHAN 2015)** reveal an 'unpredictable, geographically variable and unreliable system of perinatal mental health care populated by a broad range of primary care professionals all of whom had variable levels of awareness, interest, linkage with each other, knowledge and skills' **(KHAN 2015 P.16).** In order to plan for the future to ensure that the mental health needs of all mothers are identified and met it is necessary to clarify the roles and responsibilities of the different professionals involved in the perinatal mental health pathway of care. If the potential pivotal role that HVs have to play in the identification and management of maternal MHPs is to be realized it is first necessary to understand and describe what they are doing at the moment, as well as consider the factors that influence their practice.

An on-line survey was chosen as the method for seeking the views of HVs because of the advantages (compared with other distribution options) of reduced cost; shorter response times; ease and flexibility of question generation and design; ease of completion; and improved data quality **(DYKEMA ET AL, 2013).** Disadvantages include lower response rates as a result of premature disengagement from the survey and subsequent non-inclusion of incomplete data; technical difficulties; time constraints imposed by clinical responsibilities; limited internet access; issue salience; and concerns about confidentiality and bias **(VAN GEEST & JOHNSON, 2013).**

Cross-sectional surveys provide information about a specific issue at a particular moment in time. For the information derived from the survey to be meaningful it must include the views of a representative sample of the target population. As participation can be affected by perceptions of the salience of the issue, a decision was made to deliberately target HVs who might be interested in perinatal mental health as well as those HVs who, by their membership of the IHV, indicated their interest in the pursuit of excellence in HV practice.

The method and results of the survey are presented in Chapter 7.

2.3.6. Modelling process and outcomes

The penultimate stage of the enhanced development phase of the MRC guidance for complex interventions **(BLEIJENBERG ET AL, 2018)** involves bringing together the learning from the previous five stages in order to order to 'prioritise, reduce, select and refine' the components most likely to confer benefit that will also achieve the best fit with practice and context **(BLEIJENBERG ET AL, 2018 P.90).** Clarification is needed regarding what should be included in the intervention, how it should be delivered and the outcomes that can be expected.

What was therefore required in this stage of the research was an interactive, iterative feedback method for evaluating the components of the intervention that also captured the intuitive insight, experiential knowledge and reflexive understanding of HVs. The ultimate objective is to reach a 'fusion of horizons,' that reflects stability of collective opinion **(GUZYS ET AL, 2015).** The method and findings of the real-time, modified technological Delphi approach intended to fulfil this objective are described in Chapter 8.

2.3.7. Intervention design

The expected final output of the development process is a full prototype of the intervention **(BLEIJENBERG ET AL, 2018)**. This was manifest in the form of the manual/guide for practice. The guide was given to the expert HVs who participated in the Delphi approach to take away and read and to consider its relevance for practice prior to informal feedback at a meeting three months later. Feedback was unanimously positive. The content of the guide is summarized in Chapter 9.

2.4. Chapter summary

This chapter on methodology and methods has explained how the underlying philosophical assumptions foster a methodology based on good judgement, responsible principles and a creative approach to understanding **(LAVERTY, 2003)**. The need to accommodate the complexity of delivering complex interventions within complex systems requires a variety of research methods that explore the topic of interest from multiple perspectives. The 7 stages of the enriched development phase of the MRC guidance for developing and evaluating complex interventions **(BLEIJENBERG ET AL, 2018)** are used to provide the framework for the investigation of some of these different perspectives and each stage has been described in greater detail to generate enhanced understanding about how all the constituent parts fit together. An explanation of the relevance of each stage to the exposition of the problem has been provided as well as the research methods that are considered appropriate to investigate each of the elements of the framework. Pawson (2006) maintains that the nature of complex interventions means that evaluation of them is inevitably interpretive from start to finish and this fits with the assumptions of philosophical hermeneutics. Each of the following chapters will describe the methods and findings of each of the stages of the research that are inevitably influenced by my own professional and research heritage.

Chapter 3. Problem Identification and definition

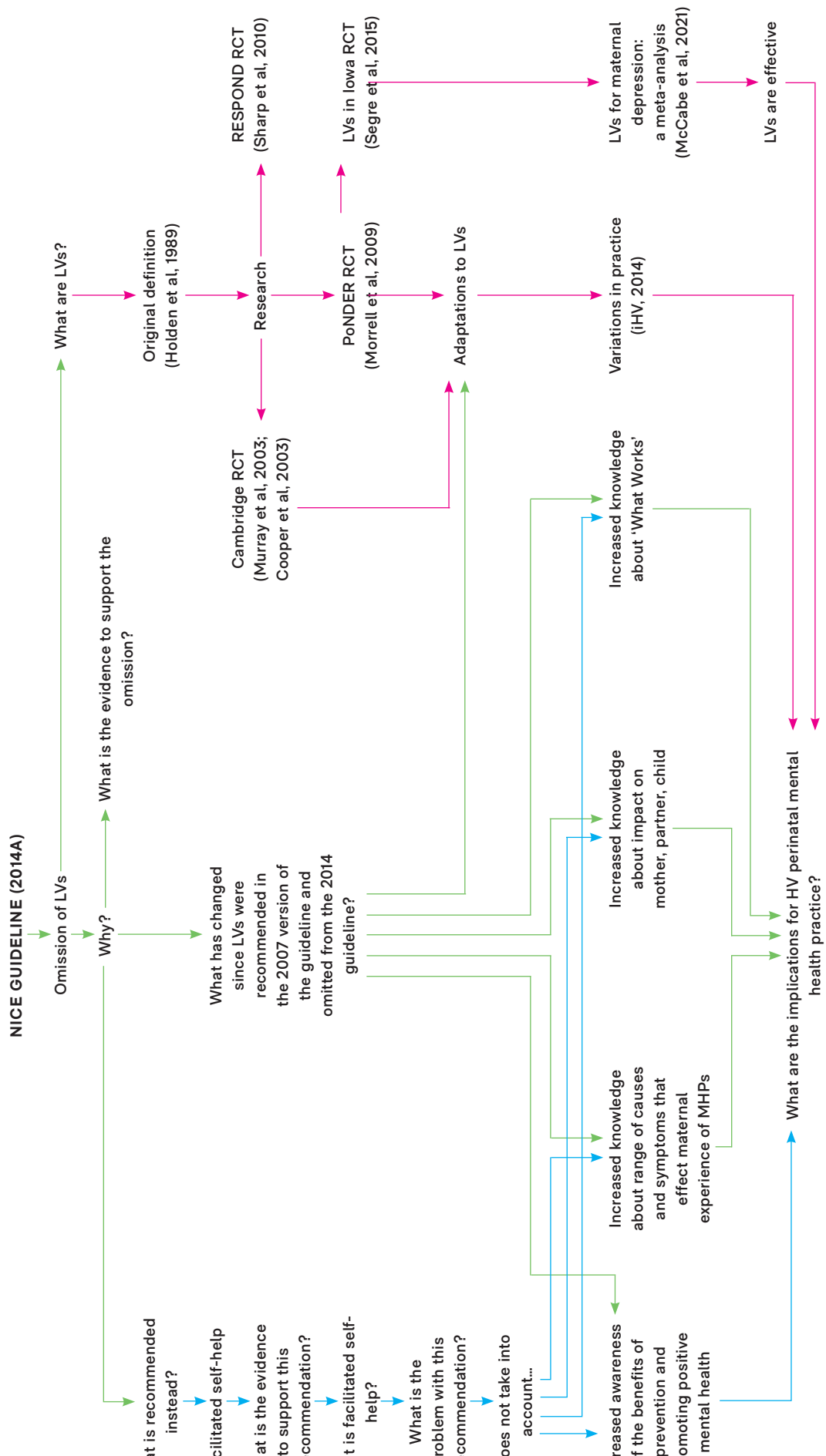
3.1. Introduction

Bleijenberg et al (2018) specify that an in-depth understanding of the problem that needs to be addressed is required in order to develop an appropriate intervention. This chapter explores some of the contributory factors that have led to the need to think differently about LVs but also highlights some of the challenges of disentangling the issues common to the clarification of problems of mental ill-health health, and the systems set up to manage them **(HANNIGAN & COFFEY, 2011)**.

The problem centres around whether HVs should still be offering LVs to mothers with MHPs given that LVS were omitted from the NICE guideline for antenatal and postnatal mental health when it was updated in 2014 **(NICE, 2014A)**. The first part of the problem that needs to be investigated is why this happened. As a result of a critical appraisal of the evidence underpinning the recommendation in the guideline, it was apparent that greater clarity was needed about what is meant by LVs, and why there might be variations in understanding about their definition and purpose. It is also important to know why LVs were introduced in the first place and whether they are still needed. This requires an exploration of the scale and impact of the MHPs that LVs were designed to address.

This chapter is divided into sections to make it easier to describe the research methods, results and conclusions for each of the component parts of the hermeneutic circle that represent the problem that needs to be solved. The first section is the critical appraisal of the NICE guideline, the second examines the definition and evolution of LVs. and the third describes the scale and impact of perinatal mental health problems. See Fig 3.1 for the flow chart for the process of problem identification.

FIG 3.1 FLOW CHART ILLUSTRATING REFLEXIVE THINKING RELEVANT TO PROBLEM IDENTIFICATION AND DEFINITION



Section 1

3.2. Examining the evidence that led to the omission of LVs from the NICE guideline for antenatal and postnatal mental health: A critical appraisal.

3.2.1. Introduction

The intention of all NICE guidance is to make evidence-based and cost-effective recommendations for the provision of health and social care, in order to reduce variations in practice and improve patient outcomes **(NCCMH, 2014 P.12)**. The original NICE guideline for antenatal and postnatal mental health was launched in 2007 in response to concerns about the incorrect use of the term 'postnatal depression' to describe all presentations of mental health problems in the year after birth and the growing recognition of the equal importance of considering antenatal mental health problems and pre-existing mental illness.

In 2012, the team at NICE considered that it was necessary to revisit the guideline in the light of the recognition of the global burden imposed by mental health problems in general; accumulating evidence about the range and severity of mental health problems that mothers can experience in the perinatal period; continuing uncertainty about the management of certain aspects of maternal mental illness; poor implementation of the recommendations in the 2007 guideline; lack of co-ordination between services; the growing body of literature emphasizing the potential adverse consequences for the child; and analyses revealing the economic consequences for society of failing to identify and treat perinatal mental illness **(NICE, 2007A; NICE, 2014A)**.

The evidence explaining the rationale for the recommendations in the NICE guideline for antenatal and postnatal mental health is available on the NICE website **(NCCMH, 2014)**. Chapter 7 of the evidence contains the relevant information about psychological and psychosocial interventions, including LVs **(NCCMH, 2014)**. The evidence that is being assessed in this critical appraisal relates to the decision of the guideline development group to exclude LVs as a recommended intervention and to make facilitated self-help the only recommended intervention for mothers with sub-threshold symptoms or mild to moderate presentations of anxiety or depression.

3.2.2. Method

Critical appraisal involves systematically examining the quality of evidence to judge the trustworthiness of the recommendations **(LUNNY ET AL, 2021)**. Flottorp et al (2013) have developed a checklist to identify the determinants of health professional practice, based on a systematic review and consensus process. One of the 7 domains in the checklist is 'guideline factors'. Flottorp et al (2013) suggest the use of 7 questions to explore the validity of recommendations within guidelines (table 3.1).

TABLE 3.1. GUIDELINE FACTORS CHECKLIST (FLOTTORP ET AL, 2013)

What is the quality of the evidence supporting the recommendation and has it been assessed appropriately?
What is the strength of the recommendation, has it been assessed appropriately, and are the implications of the strength of the recommendation clearly communicated?
Is the recommended action (what to do) stated specifically and unambiguously? Is sufficient detail provided to allow the targeted healthcare professionals to perform the recommended action?
Is the recommendation culturally appropriate?
Is the guideline or recommendation accessible?
Do the organisation(s) and people who made the recommendation have credibility with the targeted healthcare professionals?
Is the recommendation consistent with recommendations in other guidelines with which the targeted healthcare professionals might be familiar?

3.2.3. Results

The results are presented in response to each of the questions in the checklist.

Question 1: What is the quality of the evidence supporting the recommendation and has it been assessed appropriately?

Issues with the quality of the evidence, in general, are raised in a qualifying statement in the preface to the full evidence:

'Guidelines are not a substitute for professional knowledge and clinical judgement. They can be limited in their usefulness and applicability by a number of different factors: the availability of high-quality research evidence, the quality of the methodology used in the development of the guideline, the generalisability of research findings and the uniqueness of individuals'. **(NCCMH, 2014 P.11).**

It is very difficult to assess the quality of the evidence that led to the omission of LVs from the NICE guideline (NICE, 2014A). The methodology for the formulation of relevant questions, the inclusion/exclusion and quality appraisal criteria used to select appropriate studies, and the formulae used in the comparative analyses of effectiveness and cost-effectiveness are all provided in the 900+ pages of the evidence document **(NCCMH, 2014)** that accompanies the NICE guideline **(NICE, 2014A)**. The problem is that the included studies are listed at the beginning of each section but not necessarily referenced next to specific statements, or the tables where the data is presented, so it is difficult to appreciate which studies are being compared or alluded to, and to critically examine the assumptions made or conclusions reached.

There seems to be a dearth of high quality research evidence to conclude that facilitated self-help should be the recommended intervention, and LVs should not be recommended, for mothers with mild to moderate MHPs. Only two studies are considered in the comparison of LVs with CBT: one of these is comparing the two arms of the three arm HV study (one based on a person-centred approach and one based on a cognitive behavioural approach) in the PoNDER RCT **(MORRELL ET AL, 2009)(NCCMH, 2014. TABLE 121. P.371)**. The conclusion of the PoNDER RCT was that both interventions delivered by HVs were more or less equally effective so to compare one HV intervention against the other will indicate negligible difference in outcome.

Five studies are considered for inclusion in the comparison of LVs with treatment as usual: one of these is again the PoNDER RCT comparing the person-centred approach with the control group **(MORRELL**

ET AL, 2009); one is the Cambridge controlled trial (COOPER ET AL,2003; MURRAY ET AL, 2003); one is the Edinburgh study (HOLDEN ET AL, 1989); one is an RCT of LVs conducted in Sweden based on the Edinburgh protocol (WICKBERG & HWANG 1996); and the final study is an RCT of the effectiveness of extended social support provided by HVs (described as LVs) but offered monthly over 12 months and not specifically directed at the treatment of maternal mental health problems, although scores on the EPDS were used as an outcome measure (WIGGINS ET AL, 2005). As 731 out of the total 1,018 participants included in the meta-analysis were participants in the Wiggins et al study, it is likely that this study distorted the results that informed the decision not to recommend LVs.

With regard to the evidence used to inform the recommendation to offer facilitated self-help to mothers with mild to moderate anxiety or depression, only three studies provided the evidence for this conclusion. Two of the studies were based on two versions of the same CBT informed web-based intervention offered to mothers accessing the netmums website (O'MAHEN ET AL 2013A; O'MAHEN ET AL 2013B). The third study was based on a nine unit, self-guided, 'Towards Parenthood' workbook with weekly telephone support from a psychologist or trainee psychologist (MILGROM ET AL, 2011). Despite the fact that the authors of both these studies emphasise the benefits of modifying the self-help intervention to respond to the specific mental health needs of parents during the transition to parenthood, the NICE guideline recommends that facilitated self-help should be delivered as recommended in the NICE guideline for the recognition and management of depression in adults (NICE, 2009).

Based on the sparse and heterogenous evidence, both LVs and facilitated self-help were considered to be effective for mothers with mild to moderate depression or sub-threshold symptoms (NCCMH 2014, P.629). A decision-analytic model was therefore used to assess the comparative cost-effectiveness of these two interventions based on estimated costs. Estimations of costs for the three self-help studies (MILGROM ET AL, 2011; O'MAHEN ET AL, 2013A; O'MAHEN ET AL, 2013B) did not include the costs of the total number of adjunctive support sessions provided by either a psychologist or a specialist HV so represent an under-estimation of cost. Estimations of costs for LVs were based on the PoNDER trial (MORRELL ET AL, 2009) and the Wiggins et al (2005) trial that should not have been included in the analysis and inevitably contributes to an over-estimation of cost. The decision to recommend facilitated self- help and not recommend LVs in the NICE guideline was finally determined by the estimates of cost-effectiveness. It would appear that this decision is based on erroneous data and inaccurate assumptions.

Question 2: What is the strength of the recommendation, has it been assessed appropriately, and are the implications of the strength of the recommendation clearly communicated?

The way that the recommendations in NICE guidelines are presented is open to (mis) interpretation and this is of particular concern when one considers that under the conditions of the 2012 NHS Health and Social Care Act, commissioners are expected to use these recommendations to inform their commissioning decisions (LOCAL GOVERNMENT ASSOCIATION, 2012). On page 171 of the NICE guidelines manual (NICE 2014B), it is stated that the strength of any recommendation is reflected in the words that are used. Words such as 'offer', 'measure', 'advise', 'commission' or 'refer' are used to indicate a strong recommendation underpinned by clear evidence of benefit. The word 'consider' is used to describe interventions where the 'evidence of benefit is less certain' (NICE 2014B). The meaning of the term 'consider' is further expanded on page 175 of the manual, to suggest that it is used for recommendations for which there is a 'closer balance between benefits and harms' (NICE 2014B). It is possible that many people reading the guideline for antenatal and postnatal mental health (or any other guideline) are not aware of this fact. When commissioners, managers or practitioners read that facilitated self-help should

be 'considered' for women with sub-threshold symptoms or mild to moderate depression, and no other options are suggested, then it is not surprising if an assumption is made that this is the only evidence-based intervention recommended by NICE for this client group.

Question 3: Is the recommended action (what to do) stated specifically and unambiguously? Is sufficient detail provided to allow the targeted healthcare professionals to perform the recommended action?

Definitions are provided for the interventions included in the review of the evidence underpinning the NICE guideline **(NCCMH, 2014)**. The definition of LVs states that they are 'informed by Rogerian non-directive counselling (NDC) principles of self-healing, problem resolution and growth and utilise the therapist characteristics of positive regard, genuineness and empathy. The purpose of the intervention is to help mothers to gain a better understanding of their circumstances and themselves so that they can find the solutions that are right for them' **(NCCMH, 2014 P. 213)**. NDC is also described as a person-centred approach.

The definition of facilitated self-help states that it is usually based on cognitive behavioural principles that 'seek to equip people with strategies and techniques to begin to overcome and manage their psychological difficulties.' **(NCCMH, 2014 P.216)**. Written materials are provided that include 'psychoeducation about the problem and describe techniques to overcome it.' **(NCCMH, 2014 P. 216)**. The only difference between facilitated self-help and LVs appears to be that one is more directive than the other. This similarity is pointed out by a briefing issued by the iHV shortly after the launch of the updated NICE guideline **(IHV, 2014)**. LVs are described in the iHV briefing as an opportunity to use a 'suite of low intensity interventions including not only listening or non-directive counselling, but also solution focused, CBT, sleep hygiene, one to one relationship work, mindfulness, promotional & motivational interviewing, strengths based approach, supporting attachment and through directing the mother to other services or self-help.' **(IHV, 2014. P.2)**. This statement from the iHV implies that the LV interventions in the studies included in the guideline may not reflect the reality of current HV perinatal mental health practice but may emulate some of the strategies and techniques referred to in the definition of facilitated self-help.

Despite the fact that the guideline manual **(NICE 2014B P.176)** states that 'recommendations should contain enough information to be understood without reference to the evidence or other supporting material', the reader of the antenatal and postnatal mental health guideline is referred to the guideline on depression in adults for clarification of what is meant by facilitated self-help.

Any form of maternal distress can potentially have an adverse impact on maternal self-care; capacity to cope; capacity to access and engage with sources of help and support; and interactions with, and care of, the baby and other members of the family **(DH 2014)**. The NICE guideline for antenatal and postnatal mental health requires that health professionals 'acknowledge the woman's role in caring for her baby and support her to do this in a non-judgemental and compassionate way.' **(NICE 2014A, RECOMMENDATION 1.3.1)**. Health professionals are required to assess the nature of the mother-baby relationship at every postnatal contact. Suitably qualified health professionals should be available to discuss any concerns the mother may have and then consider further interventions if necessary **(NICE 2014A, RECOMMENDATIONS 1.9.12; 1.9.13)**. When psychological interventions are offered, the expectation is that they will be tailored to the specific needs of mothers and support the baby's development, attachment and mental health.

Whereas mental health professionals may not have the professional training and skills to be able to respond to maternity and childcare issues **(MILLET ET AL, 2018)**, HVs can provide holistic, integrated packages of care that address the multiple needs of the mother and take into account the health, growth, development and safety needs of the infant **(COWLEY ET AL, 2015)**. The method for assessing the mother-infant relationship or infant emotional well-being is not specified in the NICE guideline recommendations and with the emphasis on the referral of mothers with mild to moderate MHPs to IAPT services it is not clear how the needs of the infant will be considered and met **(PHE 2018D, 2018E)**.

Even though the NICE guidelines manual **(NICE 2014B)** specifies that recommendations should clearly state who is responsible for implementing the recommendation, specifically what should be done and to whom, and the anticipated setting for delivery, very little of this information is available in the antenatal and postnatal mental health guideline **(NICE 2014A)**. The guideline also recommends that psychological interventions should be delivered by competent practitioners but it does not specify what competencies are required, or how they should be assessed.

Question 4: Is the recommendation culturally appropriate?

There are multiple nuances that need to be understood with respect to the unique lived experience and expectations of individual mothers. The cultural imperative to be a positive and happy mother makes it difficult for mothers who are not experiencing motherhood in this way to speak about their experiences of distress **(STANEVA & WIGGINTON, 2018)**.

Mental illness concepts and constructs developed in WEIRD (western, educated, industrialized, rich, democratic) countries may not be valid in other cultures **(JOHNSON & WOOD, 2017)**. Aultman (2016) argues that any label associated with mental illness has moral and social implications, which can include 'discrimination, dehumanization, disrespect of persons, and lack of access to vital resources and opportunities' (p.581).

Culture influences the expression, interpretation and acceptability of symptoms and perceptions of interventions that might be considered appropriate **(EDGE & LEMETYINEN, 2019; WATSON ET AL, 2019)**. Some ethnic groups do not have a word that means depression, others are more likely to use physical symptoms as a metaphor for depression, or present with atypical symptoms not included in diagnostic criteria, and others may be constrained by cultural expectations to not discuss personal issues outside of the home **(EDGE & RODGERS, 2005; HALBREICH ET AL, 2007; HAROZ ET AL, 2017; WITTKOWSKI ET AL, 2011)**. A lack of understanding of different illness models and cultural expression can contribute to underdiagnosis, misdiagnosis and overdiagnosis **(EDGE & LEMETYINEN, 2019)**.

The evidence underpinning the NICE guideline recommendations includes a chapter on women's experiences of care. Although this chapter refers to the varied experiences of women from different cultural backgrounds, the findings are only transposed into one recommendation. This requires health professionals to provide culturally relevant information to families **(NICE, 2014A RECOMMENDATION 6.4.1.8)**. No specific recommendations are made with regard to tailoring interventions to the needs of culturally diverse individuals or how mothers from different cultural background might engage with either LVs or facilitated self-help.

Question 5: Is the guideline or recommendation accessible?

The guideline is available on the internet and therefore accessible to everybody. This has advantages and disadvantages. Universal access may increase the predisposition of patients to complain if the treatment offered does not comply with the recommendations **(MOLLON, 2009)**. Increased accessibility can lead to information overload. Clinicians accessing the NICE guideline for antenatal and postnatal mental health are advised to read 41 other associated guidelines and technology appraisals and are signposted to related practice guides, quality standards, indicators and pathways. If they want more information, they might need to read the 900+ pages of the evidence underpinning the recommendations **(NCCMH 2014)** or the 240 pages of the NICE guideline manual that explains the rationale behind the decisions and the nuances underpinning the statements that have been made **(NICE, 2014B)**. Greenhalgh et al (2014) have suggested that the sheer volume of evidence incorporated into clinical guidelines is both 'unmanageable' and 'unfathomable' (p.2) and leads to a formulaic, process-driven approach that undermines flexible, responsive, patient-centred care. Poorly specified (but easily accessible) recommendations may subvert evidence-informed practice if they are mis-interpreted, mis-remembered or mis-applied **(GREENHALGH, 2018)**.

Question 6: Do the organisation(s) and people who made the recommendation have credibility with the targeted healthcare professionals?

NICE is an independent body responsible for providing authoritative evidence-based guidance on a wide range of topics in health, public health and social care. Concerns have been expressed that the linkage of guideline recommendations to the legal requirements (stated in the Health and Social Care Act 2012) of regulatory bodies (such as the Care Quality Commission) to ensure conformity have limited patient choice and undermined clinical wisdom and shared decision making **(MOLLON ET AL, 2009; GUY ET AL, 2012; GREENHALGH ET AL, 2014)**. Evidence underpinning the recommendations may also be distorted by the vested interests of companies, researchers and the organisations responsible for setting the agenda for the development of the guideline **(MOLLON, 2009: GREENHALGH ET AL, 2014)**.

The mechanistic, reductionist model of Western medicine, that informs the recommendations in the NICE guideline tends to favour a focus on symptoms and diagnostic criteria (Mollon 2009). This approach does not adequately take into account the multiple aetiologies, comorbidities and factors that complicate the presentation or description of illness or do justice to the complexity of personal and family circumstances **(ELWYN ET AL, 2016; MOLLON 2009)**. Highly specified treatment content and over-inflated representations of effectiveness raise expectations and enhance disillusionment, amongst both patients and referring clinicians, if expected outcomes are not achieved **(MOLLON, 2009; GUY ET AL, 2012)**. The choice of outcome measures that have been used to evaluate the effectiveness of interventions and determine their inclusion in the guideline has also been subject to criticism. For example, symptom reduction may not provide the best indication of recovery from a MHP **(WILLIAMS, 2015)**.

Limited evidence is available regarding what HVs think about the credibility of NICE and the guidelines they produce, although given the frequently cited workforce pressures, it is unlikely that HVs are able to access, read, and incorporate the recommendations of all the relevant guidelines into their practice.

Question 7: Is the recommendation consistent with recommendations in other guidelines with which the targeted healthcare professionals might be familiar?

In the NICE guideline for common mental health problems, LVs is one of the recommended evidence-based interventions for mothers with MHPs **(NICE, 2011)** illustrating the difficulty of maintaining coherence across guidelines and the potential for conflicting messages for readers of guidelines.

3.2.4. Conclusions

Despite the assertion that the methods for identifying and systematically reviewing the evidence informing NICE guidelines are fair, transparent, well-described and clearly identifiable (Pilling 2012), this does not seem to be the case with regard to the presentation and robustness of the evidence pertaining to appropriate interventions for mothers with mild to moderate MHPs. The evidence is buried in the chapters of the full guideline and, once found, can be difficult to interpret and understand. Of course, this is my own interpretation, and another person investigating the evidence or using the same checklist to guide an appraisal of NICE recommendations may reach different conclusions.

The purpose of investigating the guideline was to understand the implications for health visiting practice of the omission of LVs from the recommendations. The briefing issued by the iHV (2014) suggests that the definition of LVs used in the guideline may not reflect the reality of current practice. The inclusion of an inappropriate study has skewed the meta-analysis and cost-effective evaluation of LVs. The evidence for facilitated self-help is also limited and the recommended practical application of facilitated self-help, based as it is on the guideline for the management of depression in adults, does not take into account the unique circumstances of new and expectant parents.

It is not immediately clear to readers of guidelines that the strength of the recommendations is reflected in the words that are used. The recommendation that facilitated self-help should be 'considered' does not mean that it is the only intervention that is appropriate. Equally, even though LVs are not specifically recommended it does not mean that they should not be offered, especially as the evidence on which the omission is based is limited and incorrect. It is interesting to note that since the launch of the NICE guideline, additional evidence about the effectiveness of LVs has been incorporated into an updated meta-analysis. This meta-analysis, based on 6 studies (and not including the aforementioned Wiggins et al, 2005 study), has concluded that LVs are effective **(MCCABE ET AL, 2021)**.

NICE does make it clear on the introductory webpage for every guideline that recommendations are not mandatory and should not over-ride shared decision-making and patient choice. These fundamental principles are implicit in both facilitated self-help and LVs, as the component parts of these interventions are determined by the preferences, needs and circumstances of the mother. However, the Health and Social Care Act 2012 requires that commissioning decisions are based on NICE guidance so, if commissioners are not aware of the 'small print' associated with NICE recommendations, they may invest their money in services that seem to be advocated by NICE. This is probably why the iHV sought to re-brand LVs as facilitated self-help (iHV, 2014). It matters what you call the intervention from the perspective of the guideline developers, policy makers, commissioners and managers but for health professionals coping with complexity and managing uncertainty what an intervention is called is less important than whether it improves health outcomes for the recipient. An important message arising from this analysis is that differences and similarities between interventions need to be understood and the intended flexibility of guideline recommendations should be more widely shared with those who need to know.

Section 2

3.3. What can we learn from the past to inform the future? A hermeneutic review of the evolution of LVs.

3.3.1. Introduction

The omission of LVs from the NICE guideline exacerbated an underlying confusion about what is meant by LVs. Although it has been demonstrated that the evidence leading to the exclusion of LVs and the inclusion of facilitated self-help as the recommended intervention for mothers with mild to moderate MHPs is equivocal, this revelation does not address the underlying confusion. Based on the critical appraisal of the NICE evidence, it could be argued that HVs could continue to deliver LVs, except that the version of LVs that HVs are delivering may not be the same as that described in the NICE guideline. It is not advisable to attempt to dispute the conclusions that NICE have reached and campaign for the re-instatement of LVs as a beneficial intervention if further analysis indicates variations in definition, practice and outcome. The purpose of this investigation was to review the literature about LVs in order to gain a sense of how LVs have evolved, what they are now and what they might look like in the future.

One of the principle tenets of Gadamerian hermeneutics is that 'we live in a world that recedes into the past and extends into the future' **(MOULES, 2002 P.2)**. Everything comes from somewhere so we cannot escape being influenced by what has gone before. As well as staying with the conventional interpretations of the content and ideas that are put before us, we need to be prepared to go beyond the bounds of the familiar and indulge in emergent thinking in order to reflect on the unexplained **(MCCAFFREY ET AL, 2012; SMYTHE & SPENCE, 2012)**. Reading and re-reading of literature and past experiences brings to the surface general impressions, 'perturbing and distinctive resonances, familiarities, differences, newness, and echoes' **(MOULES, 2002 P.29)**. These revelations provide additional insight into the things about the topic that we need to pay attention to, in order to know what to do next.

3.3.2. Method

This is an extension of the hermeneutic systematic review mentioned in the previous chapter. As explained in section 2.3.1 the seminal article responsible for introducing the concept of LVs **(HOLDEN ET AL, 1989)** was used as a 'citation pearl' in Google scholar, and 449 relevant articles were identified and categorized according to the main focus of the article (Table 2.1). 57 of these articles were about LVs, or the provision of perinatal mental health care by the HV. These provided the starting point for exploring connected literature through citation chaining. Searching was systematic but also flexible and iterative. Fig 2.1 in the previous chapter illustrates how a hermeneutic review consists of two interlinked cycles – the first involves accessing and interpreting the literature and the second involves developing an argument.

The search was confined to studies done in the UK and included articles published between 1989 and 2019. Comprehensive Inclusion/exclusion/quality appraisal criteria are not considered necessary in a hermeneutic inquiry because there is always some insight to be gained from someone else's interpretation of what is going on. Articles are selected based on the researcher's interpretation of their relevance to the topic under investigation.

24 articles were included in this review. The articles were saved in Mendeley reference management software and allocated descriptive tags to facilitate easy retrieval, re-examination and on-going review.

Professional awareness of the topic under review, as well as access to experts in the field, is also considered important to take into account new ideas and developments **(GREENHALGH & PEACOCK 2005)**. It was a privilege to discuss aspects of the literature and this thesis with the two of the authors of the study introducing the concept of LVs **(HOLDEN ET AL, 1989)**; the lead investigator of the largest pragmatic cluster RCT of HV interventions for postnatal depression **(MORRELL ET AL, 2009)**; one of the research HVs involved in delivering the HV intervention in the Cambridge study **(COOPER ET AL, 2003; MURRAY ET AL, 2003)**; the lead investigators involved in the transfer of LVs to Sweden and America **(SEGRE ET AL, 2010; WICKBERG & HWANG, 1996)**; three of the members of the NICE guideline development group **(NICE, 2014)**; and many health visitors currently involved in supporting mothers with MHPs. Opinions about LVs amongst this erudite group varied according to their current or prior involvement in LV research or practice and illustrated so well what Gadamer describes as the prejudgements or prejudices that we can't avoid, based as they are, on our prior beliefs and experiences.

3.3.3. Results

For the purpose of this review the articles that seemed to be relevant to the definition and evolution of LVs were those that described RCTS or pre-post evaluations exploring the effectiveness of LVs, or an equivalent intervention delivered by HVs **(APPLEBY ET AL, 1997; COOPER ET AL, 2003; COOPER ET AL, 2015; MORRELL ET AL, 2009; MURRAY ET AL, 2003; SHARP ET AL, 2010)**. Summaries of these trials, with associated spin-off research or practice development initiatives, and preliminary insights gained from analysis of the studies, are presented in Fig 3.2. *(see overleaf)*

The top half of the flow chart describes the key characteristics of the trials whilst the bottom half of the chart summarises practice developments or qualitative research indicating maternal and health professional perceptions of LVs and contextual factors that influence implementation. Arrows between the studies indicate how the effectiveness studies above the time-line are related to the acceptability/ practice development studies below the line. The time-line across the middle indicates how LVs have evolved over time but only covers the period from 1989 -2010. Further studies were identified that enhanced understanding about aspects of LV content, implementation and training **(BROWN & REYNOLDS, 2014; CUMMINGS & WHITTAKER, 2016; LYON ET AL, 2013; MORGAN, 2017; MORRELL ET AL, 2016; REGAN 2012; WILLIS, 2018)**. The purpose of hermeneutic analysis is to move away from the obvious, to reflect on what has not been said, and to expose that which is hidden.

The definition and evolution of LVs

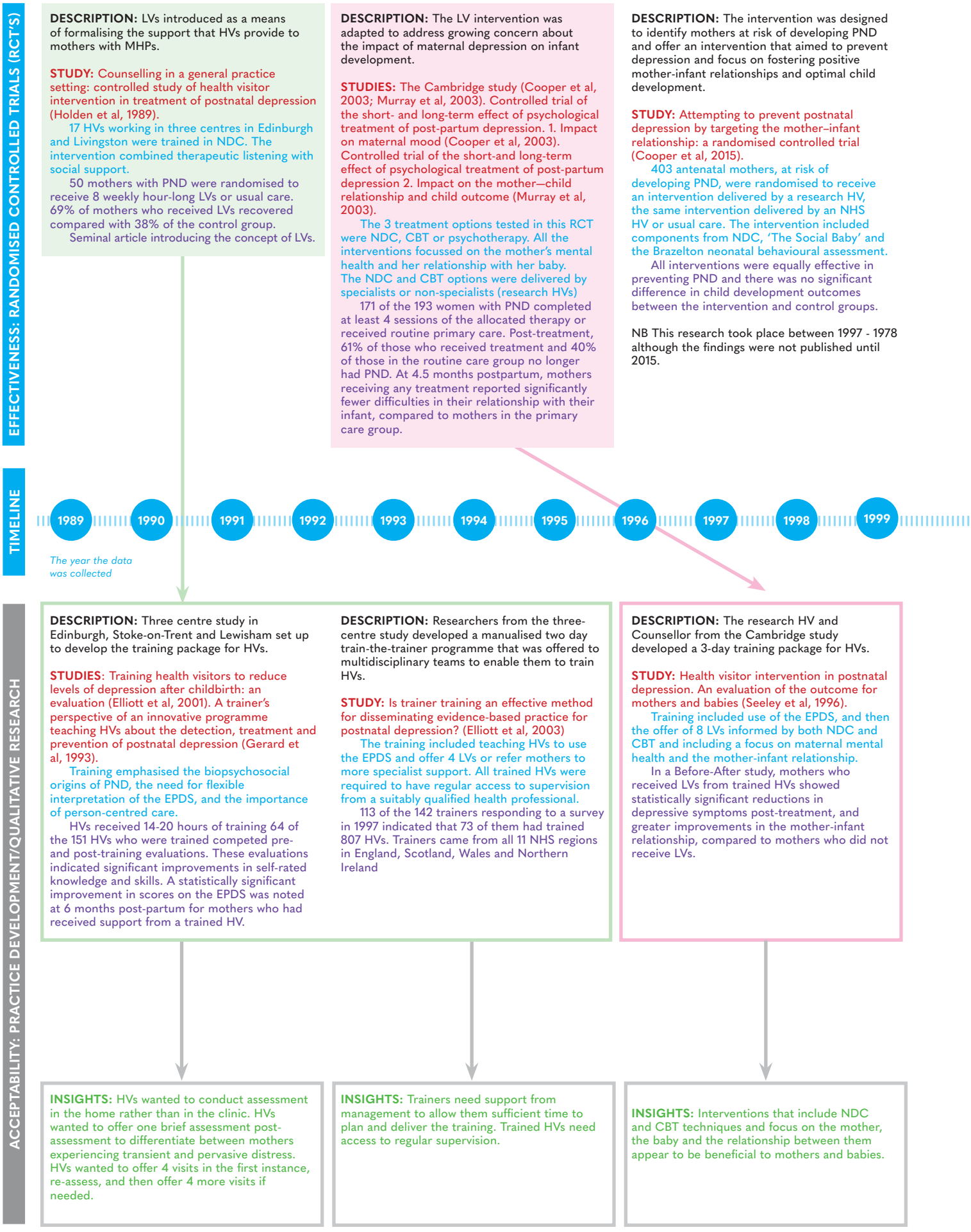
As has been discussed in section 1 of this chapter the definition of LVs used in the NICE guideline emulates the description given in the seminal article that heralded the introduction of LVs **(HOLDEN ET AL, 1989)**. This will hitherto be referred to as the Edinburgh protocol/study. This definition states that 'LVs are informed by Rogerian non-directive counselling (NDC) principles of self-healing, problem resolution and growth and utilise the therapist characteristics of positive regard, genuineness and empathy. The purpose of the intervention is to help postnatally depressed mothers to gain a better understanding of their circumstances and themselves so that they can find the solutions that are right for them' **(NCCMH, 2014 P. 213)**. The principles of NDC/person-centred care also underpin the definitions of LVs used in one of the intervention arms in the Cambridge Controlled trial **(COOPER ET AL, 2003; MURRAY ET AL, 2003)**, the PoNDER RCT **(MORRELL ET AL, 2009)** and RESPOND RCT **(SHARP ET AL, 2010)**.

Whilst it is beneficial to have a clear definition of what is included in an intervention and the skills and training required to deliver it, this does not mean that the intervention, even in research studies, will always be delivered as intended. A succinct description may provide clarity for researchers designing RCTs but it may be more difficult for health visitors to understand how to operationalise this definition. It may be the definition rather than the intervention that is easy to describe and replicate. Simplistic definitions require interpretation. The less information provided about what is expected, the more variability there is likely to be in interpretation.

The quality, duration and perceived relevance of training in LVs appears to determine HVs understanding of what is meant by LVs as well as their sense of confidence, competence and capacity to deliver them. For example, in the PoNDER trial, only fifty-nine % of HVs attending training in either the person-centred (PCA), or cognitive-behavioral (CBA) approaches were very satisfied with the training. Sixty-seven % of the HVs who attended the PCA training would recommend it to their peers, with even less (29%) of the HVs who attended the CBA training, willing to do so. Concerns about non-existent or inadequate training were expressed by HVs participating in other studies or practice development initiatives **(BROWN & REYNOLDS, 2014; CUMMINGS & WHITTAKER, 2016; MORGAN, 2017)**. The impact of the training may also be reflected in the percentage of HVs who are confident in supporting mothers with PND. In the PoNDER trial the % of mothers who were confident in supporting mothers with PND decreased from eighty % before the trial started, to seventy-four % at the end of the trial **(MORRELL ET AL, 2009)**.

The fact that less than a third of the HVs in the CBA arm of the PoNDER trial would recommend the training to their peers seems at odds with findings from other studies where HVs have been trained to use cognitive behavioural techniques, or requested training in their use **(APPLEBY ET AL, 2003; BROWN & REYNOLDS, 2014; COOPER ET AL, 2003; CUMMINGS & WHITTAKER, 2016; LYONS ET AL, 2013)**. Other techniques such as motivational interviewing, promotional interviewing, solution-focussed therapy and mindfulness have also been mentioned as a means of increasing the capacity of HVs to respond to the unique needs and circumstances of mothers **(CUMMINGS & WHITTAKER, 2016; DAY, 2014; MORGAN, 2017)**.

FIG 3.2. INSIGHTS GAINED FROM THE OVERVIEW OF THE OVERVIEW OF THE EVOLUTION OF LISTENING VISITS



DESCRIPTION: An intervention was designed to compare the effectiveness of a cognitive behavioural counselling intervention with antidepressants.

STUDY: A controlled study of fluoxetine and cognitive behavioural counselling in the treatment of postnatal depression (Appleby et al, 1997).

This 4-arm RCT involving 87 mothers compared the effectiveness of 1 session of counselling where mothers were also prescribed a placebo or antidepressants with 6 sessions of counselling with concurrent prescribing of a placebo or antidepressants. The counselling was based on cognitive behavioural principles, was offered over 6 30-minute weekly sessions and addressed typical problems experienced by new mothers.

All interventions apart from the intervention that was comprised of 1 session of counselling and a placebo led to clinically significant improvements in depressive symptoms. 101 out of the 188 women who were eligible to participate in this study chose not to do so because they did not want to take antidepressants.

DESCRIPTION: A pragmatic cluster RCT was designed to test whether training HVs in psychologically informed interventions led to a reduction in depressive symptoms in mothers with PND.

STUDY: Psychological interventions for PND: Cluster Randomised trial and economic evaluation: The PoNDER trial (Morrell et al, 2009).

The 3-arm RCT involved training 82 HVs in the use of the EPDS and supporting mothers with PND using either a Cognitive Behavioural approach (CBA) or a Person-Centred Approach (PCA) and comparing the outcomes achieved with usual care delivered by 46 HVs. The HVs delivering the PCA or CBA intervention received 8 days of training, a manual to guide their practice nad weekly contact with a research co-ordinator.595 women from 101 GP practices with scores of 12+ on the EPDS at 6 weeks postpartum were randomised, by GP cluster, to receive HV support guided by CBA, PCA or usual care.

At 6 months post-partum, after completion of the intervention, 33.9% of women who received wither the CBA or PCA intervention still scored 12+ on the EPDS compared with 45.6% in the usual care group. This difference was statistically significant but not considered clinically important.

DESCRIPTION: A pragmatic RCT was designed to compare the effectiveness and acceptability of listening visits and antidepressants.

STUDY: A pragmatic randomised controlled trial to compare anti-depressants with a community-based psychosocial intervention for the treatment of women with postnatal depression: the RESPOND trial (Sharp et al, 2010).

In a 2-arm RCT, 254 women from 77 GP practices in London, Manchester and Bristol, who were diagnosed with depression, were randomised to receive anti-depressants or usual care in the first 4 weeks post-assessment. After 4 weeks, women allocated to usual care were offered LVs. At this stage women in either group could then opt to receive the alternative intervention either instead of, or as well as, the allocated intervention. The manualised LV intervention involved a research HV, who had received two days of training, delivering 4 weekly visits to mothers. Mothers were discouraged from discussing infant care during the LVs. The mother's mental health was re-assessed after 4 weeks and a further 4 visits were offered, if needed.

As the participating women could have received both interventions by the end of the trial it was difficult to establish the relative effectiveness of the two interventions. The majority of women expressed a preference for LVs although many of them subsequently opted to take anti-depressants.

2003 2004 2005 2009 2010

DESCRIPTION: As it had been demonstrated that Cognitive Behavioural Counselling (CBC) was an effective treatment for women with PND, all HVs serving the City of Manchester were offered training in CBC. 97 (91%) of the eligible HVs attended two days of training.

STUDY: The treatment of postnatal depression by health visitors: impact of brief training on skills and clinical practice (Appleby et al, 2003).

The training included recognition and detection of PND using the EPDS and the key components of CBC that centred around child care, reassurance, enjoyable activities, practical support and behavioural targets.

A Study using a 'Before and After' design indicated that the training improved HV assessment and management of PND without increasing the cost of HV support.

DESCRIPTION: Mothers who scored 18+ on the EPDS at 6 weeks postpartum were interviewed to explore their experiences of assessment and care.

STUDY: Postnatal women's experiences of management of depressive symptoms: a qualitative study (Slade et al, 2010).

HVs in the PoNDER trial were trained to use the EPDS to identify mothers with symptoms of depression and to use CBA or PCA to support mothers with PND over the course of 8 weekly sessions.

40% of eligible mothers did not accept the offer of support from HVs in the PoNDER trial. 30 women with EPDS scores of 18+ at 6 weeks postpartum who agreed to be interviewed to explore their experiences of assessment and care. Mothers were not aware that the HV was able to help and were more likely to accept an offer of support if they had a pre-existing relationship with their HV.

DESCRIPTION: Qualitative interview studies were undertaken to explore the experiences of mothers and health professionals of receiving and providing support for PND.

STUDIES: GPs' and health visitors' views on the diagnosis and management of postnatal depression: a qualitative study (Chew-Graham et al, 2008). Disclosure of symptoms of postnatal depression, the perspectives of health professionals and women: a qualitative study (Chew-Graham et al, 2009). Women's experiences of health visitor delivered listening visits as a treatment for postnatal depression: a qualitative study (Turner et al, 2010).

In one study, 19 GPs, 14 health visitors and 28 women were interviewed to explore how care for PND is provided and received. In another study, 22 women were interviewed to explore their experiences of LVs delivered by research HVs.

Women felt that PND was a culmination of stress/sense of loss. Women were reluctant to disclose symptoms to their GPs or HVs. 64% of the women who were interviewed felt that 8 LVs was not sufficient to lead to recovery. Those who wanted further support had a history of mental illness, previous traumatic experiences or unresolved stressful circumstances.

GPs and HVs were reluctant to label mothers with postnatal depression.

They also felt that organisational barriers made it difficult for them to provide support.

INSIGHTS: HVs trained in an intervention that incorporates cognitive behavioural techniques is cost-effective.

INSIGHTS: HVs need to provide clear information to mothers about their knowledge and skills in assessing and supporting mothers with MHPs and appreciate the importance of establishing a relationship as a pre-requisite for the provision of effective support.

INSIGHTS: Careful assessment is needed to ascertain causes of depression, and previous personal history of mental ill-health, in order to ensure that mothers receive appropriate treatment. A clear explanation needs to be given about the structure, content and purpose of LVs, as well as the availability of other services, or sources of support, that can be accessed at any time.

A simplistic definition does not include information on eligibility, number, duration, or frequency of visits required, the outcomes that are expected or the measures used to indicate need, risk, progress or recovery. LVs were originally intended as a therapeutic intervention for mothers with postnatal depression **(HOLDEN ET AL, 1989)**. Eligibility in the Edinburgh study was determined by mothers scoring 13+ on the Edinburgh Postnatal Depression Scale. This is considered to be indicative of probable depression. The diagnosis was confirmed with a diagnostic interview conducted by a psychiatrist prior to recruitment in the study. A similar process was used in the RESPOND trial. In the PoNDER trial **(MORRELL ET AL, 2009)** mothers were eligible for inclusion in the study if they scored 13+ on the EPDS on two occasions, two weeks apart. LVs were therefore intended for mothers who met the diagnostic criteria for postnatal depression. Postnatal depression is often co-morbid with anxiety. Mothers may experience atypical symptoms that are not amongst the diagnostic criteria for either anxiety or depression. The NICE guideline also refers to the need to identify and support mothers with subthreshold symptoms of common MHPs **(NICE, 2014A)**. As LVs in the RCTs were only offered to mothers with probable depression, this raises the question about the suitability of LVs for other manifestations of psychological distress.

Eight visits were considered necessary to lead to clinically significant improvements in the Edinburgh study and this number was specified, but not achieved, in the PoNDER RCT, or the Cambridge controlled trial, with the average number of visits received by mothers in these trials recorded as 4 **(COOPER ET AL, 2003; MORELL ET AL, 2009)**. When the learning from the Edinburgh trial was cascaded to other HVs, the HVs wanted to offer 1 additional post-assessment visit, to gather more information to enable them to differentiate between transient and enduring distress, and then follow up with a further 4 visits if needed, which could be extended to 8, following further review at the half-way mark **(ELLIOTT ET AL, 2001)**. A similar 4+4 combination was also the visiting protocol that was advocated from the outset, in the RESPOND trial **(SHARP ET AL, 2010)**. Some mothers in this trial would have preferred more than 8 visits. In the majority of the studies reviewed, weekly visits were specified, although reflections from one HV indicated that these might be reduced to fortnightly sessions, which then might continue for as long as was considered necessary (Willis, 2018). There seems to be a lack of consensus about the number and frequency of visits that is optimally beneficial for mothers and practically feasible for HVs to deliver.

The Cambridge controlled trial of psychological treatments for postnatal depression was developed specifically to investigate the potential impact of maternal postnatal depression on the mother-infant relationship **(COOPER ET AL, 2003; MURRAY ET AL, 2003)**. This represented a departure from the Edinburgh protocol which advocated a focus on the mental health of the mother, to the extent that mothers were asked to make alternative arrangements for the care of their baby during LVs **(HOLDEN ET AL, 1989)**. Neither the PCA nor the CBA in the PoNDER RCT included any specific reference to how health visitors might assess and promote the mother-infant relationship although outcome measures included assessment of child development **(MORRELL ET AL, 2009)**. In the RESPOND RCT, mothers were encouraged to talk to their own HV about any infant care issues, so that they could focus on their mental health during LVs, provided by research HVs. It would therefore seem that there are varying opinions regarding whether the mother's feelings about, and interactions with, her baby should be addressed within a LV intervention.

Contextual factors that include the availability, accessibility or acceptability of other services also determine how HVs perceive the purpose of LVs and subsequently how they describe LVs to mothers and others **(CUMMINGS & WHITTAKER, 2014)**. Re-organisation of services, overwhelming workloads and conflicting priorities reduce opportunities for developing trusting relationships with women that would enable disclosure of distressing symptoms **(CHEW-GRAHAM ET AL, 2009; CUMMINGS & WHITTAKER, 2016; MORGAN, 2017)**. Other factors limiting HV confidence in delivering LVs include the complexity of identifying and responding to underlying factors that might contribute to maternal distress, the range and severity of symptoms that mothers might experience and lack of time for reflection and access to supervision **(CUMMINGS & WHITTAKER, 2016; MORGAN, 2017; REGAN, 2012)**.

3.3.4. Conclusions

This investigation into the evolution of LVs has demonstrated the benefits of exploring how and why LVs have changed over time. It would appear that the definition of LVs that formed the basis of the omission of LVs from the NICE guideline no longer reflects what HVs do. Although the descriptive term LVs may still be used to describe the support that HVs offer to mothers with MHPs, it would appear that the nature of the MHPs that mother experience is much more complex than was previously assumed and, in many cases, the content and purpose of LVs reflect that complexity. Standardisation of the description of LVs is evident in research protocols but does not seem to be reflected in the available literature about how LVs are delivered in practice. There seem to be variations in eligibility criteria, techniques used, and the duration, focus and frequency of the intervention. As far as it is possible to ascertain, training and supervision are variable and may not be sufficient to contribute to consistent, competent, confident HV practice.

Consideration of maternal MHPs need to extend beyond a focus on postnatal depression. As knowledge and understanding about the causes and consequences of maternal mental ill-health has evolved, there is an indication that HVs have begun to adapt their thinking and practice to respond to the varied and complex needs of families affected by maternal psychological distress. HVs have indicated that they are aware of the need to extend their toolbox of techniques to respond to maternal MHPs but also continue to endorse the value of active listening and empathic support.

There seems to be a sense of urgency amongst some HVs to learn more, know more and do more, but also an underlying yearning amongst others for the space and time to revisit the merits of authentic connection, reflective judgement, common sense and practical wisdom. Perhaps this indicates the circular notion of discovery exemplified by the hermeneutic circle, with a return to what could be considered as the principles underpinning the original definition of LVs.

Section 3

3.4. Why do we need 'Listening Visits'? A review of the prevalence and impact of common perinatal mental health problems.

3.4.1. Introduction

LVs were introduced as a therapeutic intervention that could be offered by HVs to mothers with postnatal depression because of the failure to identify and support the significant proportion of mothers who experienced this mental disorder. The NICE guideline for antenatal and postnatal mental health was updated in 2014 in response to a greater awareness of the range of MHPs that mothers might experience, and the repercussions of not identifying and treating these MHP's on mothers, their babies and society **(NICE, 2014A)**. There is some evidence to suggest that LVs have been adapted to respond to this increased awareness. The purpose of this investigation is to establish whether LVs will be an appropriate intervention to respond to the range of MHPs that mothers might experience whilst also ameliorating the potential adverse impact on the baby. In order to decide whether LVs can respond to these issues, it is necessary to clarify what those symptoms and MHPs might be, and the kinds of infant problems that might represent a manifestation of maternal psychological distress.

Identifying the significance and impact of mental health problems that mothers might experience is a complex issue. The dominant medical paradigm classifies mental disorders as discrete entities 'characterised by distinctive signs, symptoms and natural histories **(LILIENFIELD & TREADWAY, 2017 P.435)**. Classification systems such as the International Classification of Diseases (ICD) and the Diagnostic Statistical Manual of Mental Disorders (DSM) have been developed to standardise the categorisation of mental illness to make it easier to identify individuals who might be at risk of developing a disorder, and to diagnose the disorders that individuals might be experiencing, in order to determine the most appropriate treatment that might be offered. However, critics suggest that the clinical utility of these symptoms is limited: exposure to the same underlying causes can result in a range of symptoms that may cross diagnostic categories; symptoms may meet the criteria for more than one MHP (comorbidity); or the number of symptoms may not fulfil the criteria to warrant a particular diagnosis (sub-threshold symptoms) **(CLARK ET AL 2017; LILIENFIELD & TREADWAY, 2017)**.

It has also been proposed that mental disorders are socially constructed interpretations of symptom sets and characteristics of individuals informed by a 'medical-psychological-pathologising' perspective **(WALKER, P.71)**. The DSM criteria are criticized because of the use of a biomedical foundation for the categorization of mental illness and the failure to recognize contextual influences on the causes and presentation of symptoms. As symptoms exist on a continuum from wellness to illness, diagnoses based on arbitrary cut-off points based on number and severity of symptoms may not be the best way to identify individuals who would benefit from a therapeutic intervention **(BREDSTRÖM, 2017)**.

Opinions regarding what is normal or abnormal, acceptable or not acceptable, or the distinction between being mentally well and mentally unwell, are regulated by culture and subject to change as new knowledge and ideas about causes, symptoms and treatment emerge **(MCCANN, 2016)**. This is of particular relevance in relation to the mental health of mothers during pregnancy and the year after delivery where individual responses to the biopsychosocial changes involved in the transition to motherhood lead to a range of symptoms of varying significance and severity that collectively may, or may not, be perceived as a MHP, or surmount the threshold for a diagnosable disorder **(MATTHEY, 2010)**. This creates challenges for determining significance of symptoms, levels of need, impact on others, and eligibility for interventions **(AYERS ET AL, 2015)**.

Nevertheless, there needs to be a system in place for ascertaining the scale of the problem and the likely consequences for the mother, her family and society. According to the DSM, a mental disorder is defined as 'a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning' **(AMERICAN PSYCHIATRIC ASSOCIATION (APA), 2013, P.20)**. Within the medical literature mental disorders may also be referred to as MHPs, psychiatric disorders and mental illnesses.

HVs have a responsibility to detect and respond to variations in health and need at every contact. **(ADAMS 2012)**. Unlike mental health professionals who provide treatment for individuals who meet the criteria for a diagnosable mental illness, the remit of HVs is not just about identifying a need for health care (illness) but it is also about acknowledging a 'need for health' that depends on the 'many inter-related components which interact in such a way that the overall effect constitutes health (or illness)' **(WADE 2009)**. Health visitors are therefore not only seeing women with identified concerns or symptoms indicative of mental illness but have a remit to support health-promoting lifestyles, behaviours, environments and relationships **(COWLEY ET AL 2015)**. The investigation of the range and impact of MHPs is considered in the context of how the continuum of mental health need and care relates to the role of the HV and the support that HVs might be able to provide.

3.4.2. Method

To explore the prevalence of perinatal MHPs three of the most frequently cited sources for prevalence **(O'HARA ET AL, 1996; GAVIN ET AL, 2005; GAYNES ET AL, 2005)** were used as 'pearls' for a further citation search using Google scholar. Although it is interesting to see how methods for measuring prevalence have evolved over time, more recent estimates of the size of the problem are those most relevant to the development of present day interventions. Therefore, the included information about prevalence was extracted from 30 systematic reviews, meta-analyses or overviews published between 2013 and 2019, written in English, and including data relevant to women living in the U.K. Articles were stored and categorised using Mendeley reference management software. No critical appraisal system was used. Prevalence figures were cross-checked with each other to see if they had used equivalent systems to determine prevalence and to see if the results were comparable and appeared to make sense.

With regard to the impact of perinatal MHPs, a comprehensive systematic review of the effects of perinatal mental disorders on the foetus and the child was reported in the Lancet in November 2014 **(STEIN ET AL, 2014)**. This article was used as the 'pearl' citation in Google scholar to facilitate backward and forward tracking of relevant articles. 69 articles were retrieved. Reference to the impact on the child was also frequently made in articles about LVs and effectiveness of interventions. Information about the impact on the child was also derived from these sources. Mendeley reference management software was used to store and categorise articles.

Neither of these reviews exploring prevalence and impact are meant to be exhaustive, exclusive or reproducible. The approach to this review of the literature was creative rather than reproductive inasmuch as it involved interpretation and exploration of an interconnected network of assumptions, ideas and research findings **(MONTUORI, 2005)**. The body of knowledge about the prevalence and impact of perinatal mental health disorders has some unifying characteristics but is constantly being re-visited in terms of how these issues are explored and expressed. For example, prevalence depends on what we mean by mental health problems as well as how and when they are assessed. The impact of mental health problems can be framed in many different ways including the psycho-neuro-immunological causes of symptoms and the neuro-physiological foundations of observable impacts. It is impossible to include everything that might be relevant so, in the context of a Gadamerian approach to understanding, I am referencing literature and ideas that seem to make sense to me and seem to be relevant to the dual consideration of the impact of maternal mental ill-health on the mother and the developing child, and the role of the health visitor.

3.4.3. Results

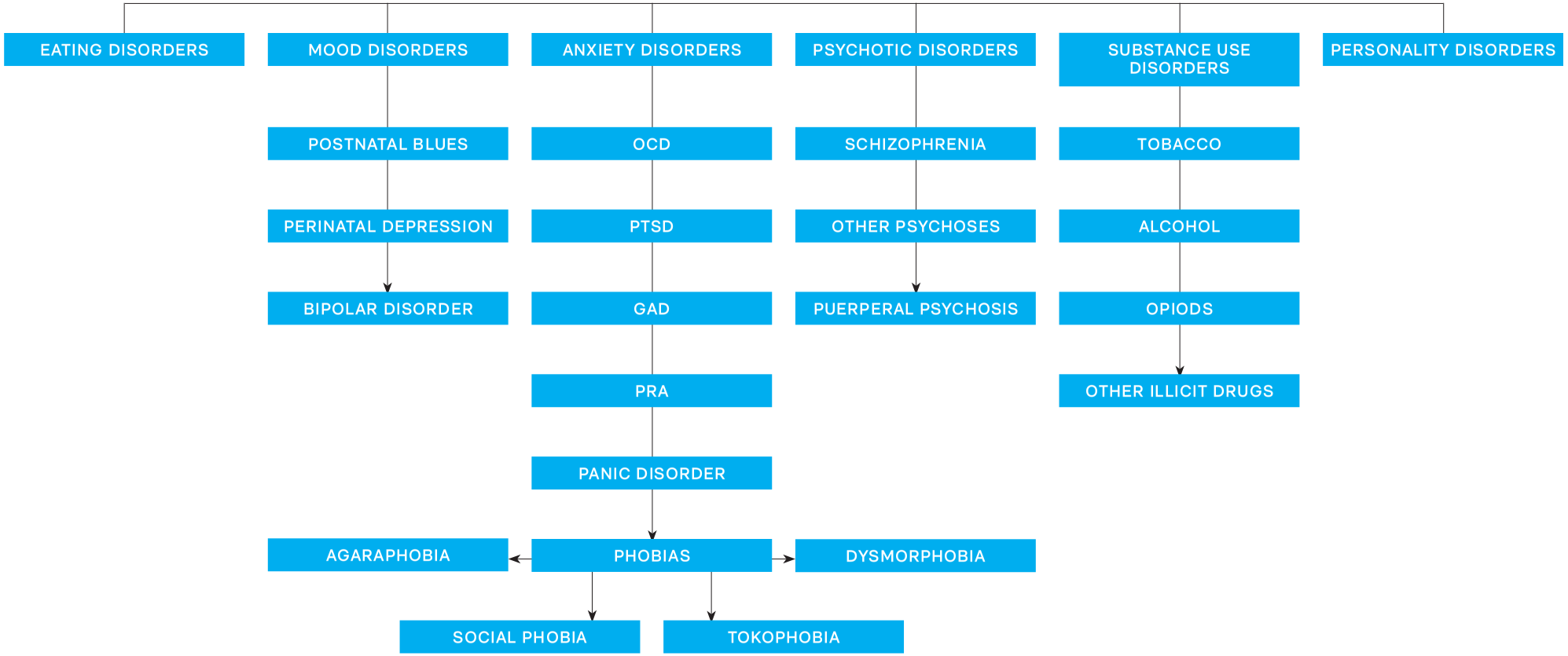
3.4.3.1. RANGE OF PERINATAL MENTAL HEALTH PROBLEMS

The full evidence underpinning the NICE guideline for antenatal and postnatal mental health **(NCCMH, 2014)** directs clinicians to be aware of the broad range of perinatal MHPs that mothers might experience including depression, anxiety disorders, eating disorders, drug and alcohol-use disorders and severe mental illness such as bipolar disorder, puerperal psychosis, schizophrenia and severe depression. The scope of the NICE guideline includes mothers experiencing MHPs across a continuum of severity, including women with sub-threshold symptoms **(NCCMH, 2014)**. See Fig 3.3. for an overview of the range of MHPs that mothers might experience during the perinatal period.

Fig 3.3. Range of mental health problems that mothers might experience during pregnancy or the first postpartum year (Brockington et al, 2006; Paschetta et al, 2014). *(right)*

The most common perinatal MHPs are depression and anxiety. However, the current disease classification systems - the Diagnostic Statistic Manual (DSM) and the International Classification of Diseases (ICD) do not present perinatal depression or anxiety as distinct diagnoses. The definitions are based on the general criteria for anxiety or depression with specified onset during pregnancy or within four (DSM) or six (ICD) weeks of giving birth.

FIG 3.3. RANGE OF MENTAL HEALTH PROBLEMS THAT MOTHERS MIGHT EXPERIENCE DURING PREGNANCY OR THE FIRST POSTPARTUM YEAR (BROCKINGTON ET AL, 2006; PASCHETTA ET AL, 2014)



OCD – Obsessive Compulsive Disorder
PTSD – Post Traumatic Stress Disorder
GAD – Generalised Anxiety Disorder
PrA – Pregnancy Specific Anxiety

3.4.3.2. SYMPTOMS OF PERINATAL DEPRESSION

Symptoms of perinatal depression may include depressed mood; anhedonia (loss of interest or pleasure in things); fatigue; changes in appetite and weight; repetitive intrusive thoughts; feelings of worthlessness or excessive or inappropriate guilt; difficulty concentrating and making decisions; feeling wound up or slowed down; disrupted sleep including difficulty falling asleep, early morning waking or wanting to sleep all the time; thoughts of suicide, self-harm or thoughts about inflicting, or being responsible for, harm to the baby **(HOWARD ET AL, 2014; LAWRENCE ET AL, 2017)**. A diagnosis of depression requires that individuals must be experiencing at least 5 of these symptoms, one of which must be either depressed mood or anhedonia. The symptoms must be present on most days for at least two weeks and 'cause significant distress or impairment in social, occupational or other important areas of functioning' **(APA, P.20)**.

One of the main concerns of mothers experiencing MHPs is the impact of their symptoms on their ability to function as a mother, with the associated fear that if they share their symptoms with a health professional, that their baby will be removed from their care **(DENNIS AND CHUNG-LEE, 2006; BOOTS FAMILY TRUST ALLIANCE, 2013)**. It is therefore impossible to consider the size of the problem that needs to be addressed without considering maternal functioning in the context of the transition to motherhood and the sometimes overwhelming responsibility of looking after a baby. This represents one of the challenges in defining the scale of the problem and the types of intervention that are needed as, historically, assessments and interventions delivered by health professionals have not automatically included consideration of the impact on the child.

The stigma surrounding mental illness in general, and perinatal mental illness in particular, has a negative influence on the number of women who are willing to share how they feel with a health professional **(BOOTS FAMILY TRUST ALLIANCE, 2013; RUSSELL ET AL 2017; NATIONAL CHILDBIRTH TRUST 2018)**. It has been suggested that 50% of women with MHPs are not being identified or not receiving the help they need that will lead to recovery **(COX ET AL, 2016)**. Prevalence figures are therefore likely to underestimate the number of women affected by perinatal MHPs. As well as dependence on diagnostic criteria, estimates of prevalence depend on the timing, method of assessment and/or interpretation of scores on self-report measures used to signify a MHP.

3.4.3.3. PREVALENCE OF PERINATAL DEPRESSION

Global prevalence of postpartum depression (PPD), based on 291 studies from 56 countries aggregating the findings from 296,284 woman and using a cut-off point on the Edinburgh Postnatal Depression Scale (EPDS) of ≥13 (indicating probable depression) was 16.7% **(HAHN-HOLBROOK ET AL, 2017)**. The estimated prevalence of PPD for the UK in this study was 16%. In another review of the worldwide prevalence of postpartum depression, Norhayati et al (2015) found a prevalence range of 10 – 18% for the UK, assessed using a score greater than 12 on the EPDS and based on 5 studies involving 17,716 women. Estimates of the prevalence of postpartum depression in developed countries in this study ranged from 5.2 – 74%.

Analysis of data from the UK Health Improvement network (which has access to GP records for 6% of the population), and based specifically on a cohort study analysing the records of 206,517 women between 2000 and 2013, found that 11% of women had entries in their medical record indicative of depression in the first postnatal year **(PETERSEN ET AL, 2018)**. A similar population prevalence of 11% for antenatal depression was estimated from a cross-sectional study involving 9,963 women who responded to the depression identification questions at their antenatal booking appointment in South East London, a proportion of whom were subsequently assessed by a suitably qualified clinician using the structured clinical interview for depression **(HOWARD ET AL, 2018)**. In the same population of antenatal women,

53% of the women scored ≥13 on the EPDS highlighting the dependence of estimates of prevalence on the method of assessment. The broad range of estimates of prevalence serves to illustrate the challenges of describing the scale of the problem and the difficulties in identifying who might benefit from a therapeutic intervention.

3.4.3.4. SYMPTOMS OF PERINATAL ANXIETY

Symptoms of generalized anxiety disorder include feeling nervous, anxious or on edge; worrying about lots of different things; feeling unable to stop or control the worrying; having trouble relaxing and difficulty sleeping; fatigue; restlessness; difficulty concentrating; becoming easily annoyed and irritable; muscle tension and palpitations **(WENZEL, 2010)**. A diagnosis of Generalised Anxiety Disorder (GAD) requires the core feature of uncontrollable worry combined with at least three of the other symptoms listed above **(WENZEL, 2010)**. The DSM criteria specify that symptoms should be present for at least 6 months. This means that mothers experiencing uncontrollable worry in relation to pregnancy or motherhood may not meet this criterion. Anxiety may present differently during pregnancy or the first postnatal year not only in terms of duration, but also in terms of the number and range of symptoms experienced, that may not meet the threshold for a disorder or may warrant an alternative diagnosis such as adjustment disorder, panic disorder, tokophobia, Obsessive Compulsive Disorder (OCD) or Post Traumatic Stress Disorder (PTSD) **(AYERS ET AL, 2015)**.

3.4.3.5. PREVALENCE OF PERINATAL ANXIETY

Global prevalence of perinatal anxiety based on 102 studies from 34 countries involving a diagnostic interview (conducted by a qualified clinician) with 221,974 women was 15.2% for any anxiety disorder identified during pregnancy and 9.3 - 9.9% for any anxiety disorder identified across the first postnatal year **(DENNIS ET AL, 2017A)**. The prevalence of GAD included in the overall prevalence of anxiety disorders was 4% during pregnancy and 4.4 – 5.7% postnatally **(DENNIS ET AL, 2017A)**. This means that over 10% of mothers antenatally and approximately 5% of mothers postnatally are experiencing some other form of diagnosable anxiety disorder **(SOMERVILLE ET AL, 2014; BAYRAMPOUR ET AL, 2016; FALLON ET AL, 2016)**. This is relevant in the context of the anxiety assessment tools recommended for use by clinicians in primary care by NICE **(NICE, 2014A)**, as these are only intended to identify the symptoms of GAD.

The pooled global prevalence of self-reported symptoms of anxiety using validated questionnaires, either antenatally or postnatally, was 22.9% and 15% respectively **(DENNIS ET AL, 2017A)**. This suggests that a large proportion of mothers are experiencing symptoms of anxiety that are not compatible with diagnostic criteria. There is an option in the DSM for a diagnosable disorder, not otherwise specified (NOS). This is used when the primary symptoms described do not fit with the specified diagnostic category. This may be the case for expectant and postnatal mothers. For example, in a sample of mothers who experienced uncontrollable worry about their baby or their role as a mother, half of them were diagnosed with GAD, whilst the other half were diagnosed with an anxiety disorder, NOS **(PHILLIPS ET AL, 2009)**. Given the multiple potential causes and consequences of anxiety during the perinatal period, it has been proposed that it might be more appropriate to use assessment tools designed to capture the intensity, duration and impact of the emotional, cognitive and somatic dimensions of pregnancy- and postnatal-specific anxiety rather than GAD **(SOMERVILLE ET AL, 2014; BAYRAMPOUR ET AL, 2016; FALLON ET AL, 2016)**. Variations in definition of what is meant by perinatal anxiety as well as differences in the timing of assessment contribute to the range of prevalence estimates given in different studies with the upper estimate suggesting that 45% of women may be affected **(DENNIS ET AL, 2017B)**.

For the UK, extrapolated estimates of population prevalence of antenatal anxiety based on a diagnostic interview of a cross-sectional survey of 545 women attending their first antenatal appointment in a South East London clinic were 17% for any anxiety disorder **(NATH ET AL, 2018)**. This includes prevalence of 5% for GAD; 4% for social phobia; 8% for specific phobia and 2% for Obsessive Compulsive Disorder (OCD). Population prevalence of Post Traumatic Stress Disorder (PTSD) was harder to estimate as women were reluctant to respond to the interview questions about PTSD. Sensitivity analyses suggest a population prevalence of antenatal PTSD of 4% **(NATH ET AL, 2018)**. This is comparable to the estimated global prevalence, based on 59 studies from 23 countries involving 24,267 women, of 3% for antenatal PTSD and 4% for postnatal PTSD **(DIKMEN YILDIZ ET AL, 2017)**.

Global prevalence estimates for perinatal OCD range from 4-9% **(CHALLACOMBE AND WROE, 2013)**. Women diagnosed with depression, or those who do not fulfill diagnostic criteria for any mental illness, may also experience obsessional thoughts of harming themselves or their babies **(FAIRBROTHER AND WOODY, 2008; MILLER ET AL, 2015)**. Seven categories of intrusive thoughts in relation to harming infants have been identified. These include thoughts of suffocation/sudden infant death; accidents; intentional harm; sexual thoughts; losing the infant; illness; and contamination **(ABRAMOWITZ ET AL, 2006)**. Fear of disclosing these distressing thoughts is one of the reasons why mothers avoid seeking help **(LAWRENCE ET AL, 2017)**.

3.4.3.6. PREVALENCE OF CO-MORBID PERINATAL MENTAL HEALTH PROBLEMS

Perinatal depression is frequently co-morbid with other mental disorders. In a secondary analysis of data from a study of new mothers in England, responses from 5,332 mothers indicated that 46% of mothers who reported anxiety in pregnancy also reported depression. Of those who reported depression, 69% also reported anxiety. At 10 days postpartum 29% of anxious mothers were also depressed and 56% of depressed mothers reported anxiety with similar prevalence of co-morbidity reported at 1 and 3 months postpartum **(HENDERSON & REDSHAW, 2013)**. A systematic review involving 24,267 women in 59 studies estimated that the mean prevalence of comorbid antenatal depression and PTSD and postnatal depression and PTSD was 44.1% and 17.72% respectively (Dikmin-Yildez et al, 2017). Individuals presenting with comorbid disorders usually have more acute and severe symptoms, are more difficult to treat and have poorer outcomes **(DENNIS ET AL, 2017)**.

Treatments for depression inappropriately offered to mothers experiencing other disorders that may be comorbid with, or incorrectly diagnosed as, depression, may not be effective. Mothers may present with symptoms compatible with the diagnostic criteria for anxiety or depression but in reality may have additional more complex and worrying symptoms indicative of, for example, bipolar disorder or puerperal psychosis **(WISNER ET AL, 2013)**. Symptoms of anxiety and depression can also mask a number of underlying and serious psychosocial comorbidities such as interpersonal violence, substance misuse or a history of adverse childhood experiences **(AUSTIN ET AL, 2015)**. Unless the co-morbidity is addressed, treatments focused on ameliorating symptoms may not be effective. Clinicians responsible for the care of mothers therefore need to be aware of the range of causes, symptoms, comorbidities and MHPs that mothers might experience.

3.4.3.7. CHRONICITY AND SEVERITY OF PERINATAL MENTAL HEALTH PROBLEMS

The most common perinatal MHP is PPD. According to Norhayati et al (2015) 50% of women with PPD reported that symptoms began during pregnancy. It has been estimated that an episode of PPD generally lasts from 2-6 months **(TSIVOS ET AL, 2015)**. The longer the depression is left untreated, the more difficult it is to treat **(GHIO ET AL, 2014)**. If not recognised and treated, maternal symptoms of depression may persist for up to five years after childbirth **(WOOLHOUSE ET AL, 2015; DENCKLA ET AL, 2017)** and even longer for a small percentage of mothers. In the Avon Longitudinal Study of Parents and Children (ALSPAC study), involving over 9,000 women, more than 2% of the population had elevated scores on the EPDS (indicative of depression) across 5 time points from 8 months to 11 years after birth **(NETSI ET AL, 2018)**.

Consideration of chronicity must include mothers with persistent sub-threshold symptoms. In a longitudinal study of 615 Canadian women followed from pregnancy until 5 years postpartum, 54% had a trajectory of moderate- stable symptoms of depression (score between 5 and 9 on the EPDS) across the five year time-frame with 29% following a moderate-stable trajectory for symptoms of anxiety (score between 4 and 6 on the anxiety subscale of the EPDS) **(AHMED ET AL, 2019)**. This illustrates the challenges of differentiating between clusters of symptoms and symptoms of diagnostic relevance and the need for continuous monitoring of maternal mental health.

Sub-threshold symptoms can increase the likelihood of transition to diagnosable disorders. A prospective cohort study involving follow up of 1,167 non-perinatal Dutch individuals either with sub-threshold symptoms, or in remission from depressive and anxiety disorders, indicated a three-four fold increased risk of experiencing an anxiety or depressive disorder in the subsequent two years compared to individuals with neither of these risk factors **(KARSTEN ET AL, 2011)**.

MHPs that occur for the first time in the perinatal period may increase the likelihood of recurrence of postpartum MHPs as well as long-term MHPs **(LETOURNEAU ET AL, 2012; NAJMAN ET AL, 2017)**. In an Australian birth cohort study following 3,337 women for 27 years after the birth of their first child, it was estimated that 9.9% of women experienced repeated episodes of clinically significant depression equivalent to experiencing depressive symptoms for almost one in every six days of their lives, subsequent to an experience of postnatal depression **(NAJMAN ET AL, 2017)**.

If mothers meet diagnostic criteria for depression within 14 days of the birth of their baby, they are more likely to subsequently convert to bipolar disorder **(MUNK-OLSEN ET AL, 2012)**. An estimated 14% of women, who have their first contact with psychiatric services in the first postnatal month, are diagnosed with bipolar affective disorder within 15 years of the initial episode **(MUNK-OLSEN ET AL, 2012)**.

A longitudinal study of Swedish first -time mothers (n=419) found that mothers who scored high on the EPDS at 10 days postpartum were more likely to experience persistent low mood and difficulties with the mother-infant relationship over the baby's first year **(LILJA ET AL, 2012)**. Although up to 85% of mothers experience 'baby blues' (mood fluctuations, crying, insomnia and irritability) during the first postpartum week, symptoms that have not resolved by 10-12 days are likely to be indicative of postnatal depression **(O'HARA AND MCCABE, 2013)**. As the health visitor is expected to undertake a holistic assessment of family health needs during the first postnatal visit at 10-14 days postpartum **(PHE, 2018 E)**, this provides an ideal opportunity to identify mothers with symptoms that warrant further investigation or treatment.

The most acute and severe perinatal affective disorder is puerperal psychosis. This usually develops between 3 and 10 days post-birth. Typical symptoms include fluctuations in mood, paranoid delusions, hallucinations, disorganised behaviour, confusion, depersonalisation, disorientation and suicidal and infanticidal thoughts **(BERGINK ET AL, 2016)**. Symptoms may be fluctuating or hidden and sensitive enquiry is needed as a psychotic presentation represents a psychiatric emergency. Women who experience puerperal psychosis may subsequently be diagnosed with bipolar disorder. For both these conditions there is a risk of relapse of 35% with subsequent pregnancies **(WESSELOO ET AL, 2015)**. This highlights the need to enquire about past history of mental illness and to be vigilant for more serious symptoms of mental illness.

3.4.3.8. SELF-HARM AND SUICIDE

In the UK and Ireland, suicide is the third leading cause of maternal deaths during pregnancy and the leading cause of maternal deaths during the first postpartum year **(KNIGHT ET AL, 2018)**. In a systematic review of 57 studies the prevalence of thoughts of self-harm in pregnancy varied from 3 – 33% **(GELAYE ET AL, 2016)**. Although the majority of women in these studies were depressed, a substantial proportion did not meet the clinical threshold for depression highlighting the importance of ascertaining the salience of other factors that increase self-harm ideation and risk such as intimate partner violence, history of child maltreatment and sleep disturbance **(SIT ET AL, 2015; GELAYE ET AL, 2016)**. In a non-clinical sample of 116 American mothers with histories of child maltreatment, suicidal ideation (SI) was measured at 4,6,12,15 and 18 months postpartum. The largest proportion of mothers (37%) endorsed SI at 4 months with 25% endorsing SI at all subsequent time points **(MUZIK ET AL, 2016)**.

In a prospective pregnancy cohort study involving 1507 Australian women, thoughts of self-harm were assessed using question 10 of the EPDS during pregnancy and at 3,6,12,18 months and 4 years postpartum. Approximately 15% of these women expressed thoughts of self-harm at least once and 7% reported persistent self-harm thoughts across all time points **(GIALLO ET AL, 2018)**. In a community based sample of 4,150 women in the UK, who were sent a postal EPDS at 6 weeks postpartum, 9% reported 'hardly ever', 'sometimes' or 'quite often' having had thoughts of self-harm **(HOWARD ET AL, 2011)**. In an online survey of 1,547 self-selected mothers who had experienced perinatal mental health problems, recruited from the Netmums website in 2012, 22% said they had experienced suicidal thoughts **(BOOTS FAMILY TRUST ALLIANCE, 2013)**.

Besides completed suicide there are other adverse long-term consequences of thoughts of self-harm. In a Swedish population – based longitudinal cohort of 2,318 postnatal women who completed the EPDS at 5 days, 6 weeks and 6 months postpartum and whose medical records were reviewed for 7 years postpartum, those women who responded positively to the self-harm question at any time point (regardless of whether they also met the criteria for probable depression) had higher rates of both psychiatric and somatic morbidity compared to non-depressed controls **(ILIADIS ET AL, 2018)**.

In the most recent national English psychiatric morbidity survey, 25.7 % of women aged 16 – 24 and 13.2% of women aged 25 – 34 reported having ever self-harmed, with the most frequently cited reasons for their actions as relief of 'feelings of anger, tension, anxiety or depression.' **(MCMANUS ET AL, 2016. CH 12. P.24)**. Two thirds of the self-harming 16 – 34 year olds in this survey had not received any medical or psychological support. Although these prevalence figures do not relate specifically to pregnant or new mothers, they indicate the underlying prevalence of self-harm in women of child-bearing age and, according to Healey et al (2013), constitute an increased risk of self-harm and suicide in the perinatal period. Preconception self-harm has also been associated with mother-infant bonding difficulties in the first postpartum year **(NIEDERKROTENTHALER ET AL, 2012)**. As self-harm may be an indication of untreated

MHPs, perinatal enquiries about personal history of mental illness should also include questions about current and past self-harm, regardless of contact with mental health services **(AYRE ET AL, 2019)**.

3.4.3.9. PHYSICAL HEALTH PROBLEMS AND MATERNAL MHPS.

Physical discomforts associated with childbirth that persist beyond the immediate postpartum period contribute to maternal psychological distress. According to a prospective pregnancy cohort study involving 1507 participants, women reporting three or more physical health problems (such as exhaustion, upper and lower back pain, severe headaches, breast problems, perineal pain, pelvic pain, urinary incontinence, haemorrhoids and constipation), in the first three months postpartum, were six times more likely to report concurrent depressive symptoms and three times more likely to report depressive symptoms at 6-12 months postpartum than mothers without this level of physical discomfort **(WOOLHOUSE ET AL, 2014)**. Mothers (n = 1072) responding to a national survey of childbearing women in the U.S.A. experienced the disruptive impact of similar physical health problems in the two months postpartum (eg physical exhaustion, sore nipples/breast tenderness, backache) **(DECLERQ ET AL, 2014)**.

Equally, acute infections, preeclampsia, peripartum blood loss and anaemia, circadian rhythm disruption and thyroid autoimmune diseases can increase vulnerability to perinatal mental ill-health in some women **(BERGINK ET AL, 2016)**. Epidurals, postpartum haemorrhage, postpartum surgery and short labour duration have been associated with an increased likelihood of depressive symptoms **(KENDALL-TACKETT ET AL, 2015)**. A national survey of 5,332 mothers in England found that mothers who had forceps deliveries or unplanned caesarians were more likely to experience depression and breastfeeding difficulties at 3 months postpartum **(ROWLANDS & REDSHAW, 2012)**. It is therefore particularly appropriate that the health professionals who are usually the first point of contact for mothers in the perinatal period, such as GPs, midwives, and HVs, are aware of the inter-relationship between maternal physical and mental health.

3.4.3.10. SOMATIC MANIFESTATIONS OF SYMPTOMS OF MHPS

Physical symptoms may be used as a metaphor for depression. In non-western countries, somatic symptoms are the main complaints of treatment seeking women interpreted by psychiatrists as indicative of depression **(HALBREICH ET AL, 2007)**. A systematic review of qualitative literature exploring how depression is experienced around the world provides a further illustration of cultural variations in symptom expression **(HAROZ ET AL, 2017)**. Four of the most frequently mentioned cross-cultural symptoms were social isolation/loneliness, crying, anger and general pain **(HAROZ ET AL, 2017)**. These are not included in the DSM-5 diagnostic criteria for depression and are therefore not routinely considered when assessing the mental health of new mothers. This illustrates so well the variations in interpretation of manifestations of 'un-ease' and the hegemony of medico-pathologizing perceptions of mental illness. The classification of symptoms into diagnostic categories is designed to make it easier for mental health professionals to diagnose and treat mental illness. The words that are used, the diagnosis that is made and the treatment that is offered may not resonate with the lived experience or expectations of the individual.

Although classification systems exist to aid in the diagnosis of MHPs, it is evident that there is significant heterogeneity in the way that mothers experience, describe and interpret symptoms that may or may not be attributable to a mental disorder, but still cause distress or compromise functional capacity and intimate relationships. Maj (2018), in an editorial for World Psychiatry, proposes that greater attention should be given to how the number and severity of symptoms accumulate or interact over time and that diagnosis is not as important as the formulation of an appropriate management plan that takes into account antecedent variables (such as family history of mental illness, perinatal factors and environmental exposures) and concomitant variables (such as personality traits, social and cognitive functioning).

3.4.3.11. IMPACT OF MATERNAL MENTAL ILL-HEALTH ON THE FOETUS/CHILD

One of the most important reasons for identifying mothers with MHPs is to prevent the potential adverse consequences for the child. During the first 1001 days of life aspects of the early nurturing environment exert a profound influence on the brain, regulatory systems and behavior of the developing foetus/infant and can affect the future health, development, achievements, relationships and well-being of that individual across the lifecourse **(LYONS-RUTH ET AL, 2017).**

It has been suggested that maternal stress represents one of 4 major pathophysiological pathways leading to pre-term birth **(GREEN ET AL, 2005**). A systematic review and meta-analysis concluded that women with untreated antenatal depression were 56% more likely to have a preterm birth (<37 weeks) and 96% more likely to have babies with low birth weight (<2.5kg) **(JARDE ET AL, 2016)** Pre-term birth is the leading cause of neonatal morbidity and mortality in the UK **(NICE, 2015).**

3.4.3.12. THE IMPORTANCE OF CONSIDERING MATERNAL SUB-THRESHOLD SYMPTOMS

Kingston et al (2018) suggest that it is a false dichotomy to label women as either depressed or not depressed when considering the impact on the child. In an analysis of data from a longitudinal cohort study of 1,983 Canadian families recruited when the mother was pregnant, children of mothers with persistent sub-threshold scores on the EPDS (score of 5 – 10) measured at 4 time points from pregnancy to 1 year postpartum were more likely to exhibit aggressive behaviour at age three (assessed using a version of the child behaviour checklist), than children of mothers with either only early postpartum depressive symptoms or persistent scores above 13 on the EPDS. Children of mothers with persistent subclinical symptoms were also equally likely as children of mothers with early postpartum depressive symptoms or persistent above threshold symptoms to show signs of hyperactivity/inattention and separation anxiety at age three. **(KINGSTON ET AL, 2018).** This replicates the findings from an Australian cohort study involving 1,085 mothers which showed that children of mothers with either persistent subclinical symptoms or persistently high symptoms of depression were at least twice as likely as children of non-depressed mothers to have emotional-behavioural problems at age 4 **(GIALLO ET AL, 2015).**

Women with persistent sub-threshold symptoms represented 30% of the sample in both the Canadian and Australian studies **(GIALLO ET AL, 2015;KINGSTON ET AL, 2018**). This carries implications for the interpretation of the use and meaning of EPDS scores and emphasizes the importance of responding to symptoms, or the causes of symptoms, rather than seeking to establish a diagnosis. This is worthy of consideration when designing interventions, given that the 72% of the economic burden imposed by maternal mental ill-health arises from the impact on the child **(BAUER ET AL, 2014).**

3.4.3.13. OTHER FACTORS CONTRIBUTING TO THE IMPACT OF MATERNAL MENTAL HEALTH ON THE CHILD

The importance of considering other factors that might accentuate the adverse impact of maternal depression on the child is illustrated with findings from a longitudinal cohort study involving over 7,000 mother-infant dyads investigating the association between maternal depression, a range of other risk factors and emotional and behavioural problems in the offspring when they were 7 years old **(BARKER ET AL, 2012**). This study showed that every additional risk factor (such as low socioeconomic status, single or teenage parenthood, intimate partner violence or limited networks of practical and emotional support) increased the likelihood of children of depressed mothers experiencing internalizing or externalizing disorders at age 7 by 20%. Three additional risk factors would therefore increase the chances of the child having a emotional and behavioural problems by 80% **(BARKER ET AL, 2013).** In another longitudinal cohort study, involving 997 mothers recruited in pregnancy, the presence of maternal symptoms of

borderline personality disorder explained the association between maternal depression and externalizing and total problems, according to maternal assessment using the Child Behavior Checklist, when the child was 2.5 years old **(HUNTLEY ET AL, 2017)**. This demonstrates that symptoms of maternal MHPs cannot be assessed in isolation from other contributory factors also likely to compromise the well-being of the child.

3.4.3.14. NOT ALL CHILDREN ARE AFFECTED BY MATERNAL MENTAL ILL-HEALTH

Not all children of depressed mothers will be adversely affected by maternal MHPs. There may be features of childhood temperament, environment and caregivers that confer resilience **(SAVAGE – MCGLYNN ET AL, 2015; GIALLO ET AL, 2018)**. A longitudinal pregnancy cohort study involving over a thousand Australian mothers found that 78% of the children of the 22% of mothers with perinatal depression were within the normal range according to the total score of the Strengths and Difficulties questionnaire at age four **(GIALLO ET AL, 2018)**. According to this study, the factors that confer emotional-behavioural resilience in the child included older maternal age, maternal tertiary education, financial security, involved and supportive partners, one hour a week of 'time for self' for the mother; and maternal engagement in child-related activities such as reading, talking and playing **(GIALLO ET AL, 2018)**.

3.4.3.15. IMPACT OF MATERNAL MENTAL ILL-HEALTH ON PARENTING.

Impact on the child is possibly mediated through the cognitive, affective and behavioural features of maternal depression and 'dysfunctional parenting behaviours' that might arise as a consequence of depression **(GOODMAN AND GARBER, 2017 P.368)**. The transition to motherhood (for all mothers) includes biologically determined alterations in behavior. These include down-regulation of the stress response (to help minimize physiological responses to acute stressors); enhanced aggression in response to threat (to protect the vulnerable infant); heightened anxiety; and enhanced sensitivity to recognition of emotions and interpretation of facial expressions **(GLYNN ET AL, 2018)**. Barrett and Fleming (2011) suggest that cognitive flexibility (ability to switch attention in response to multiple situational demands), attentional control (ability to ignore distractions and focus on the infant) and efficient working memory (ability to remember what to do and how to do it in response to infant needs) are all essential cognitive functions required in the process of adapting to motherhood. Maternal cognitive perturbations associated with MHPs that are likely to affect caregiving include executive function deficits **(DEJONG ET AL, 2016; PSYCHOGIOU & PARRY, 2013)**, negative attentional biases **(STEIN ET AL, 2010)**, self-focus, self-silencing **(BECK, 2002; EASTWOOD ET AL, 2016)**. psychological distancing **(HUMPHREYS ET AL, 2018)**.ruminatory thinking **(TESTER-JONES ET AL, 2016)**. emotional numbing **(EDVINSSON ET AL, 2017)**. and alexithymia **(TANG ET AL, 2019)**.

Maternal MHPs potentially affect the way a mother thinks about, interacts with and cares for her baby as well as the ways she feels about her ability as a mother and her enjoyment of the mothering role **(LOGSDON ET AL 2006; FIELD, 2010; GOODMAN, 2019)**. Maternal MHPs may influence the way that a mother interprets and describes infant appearance, temperament, personality, motivations and behavior **(PARFITT ET AL, 2013; ROSENBLUM ET AL, 2018)**.

Maternal MHPs may be manifest in the extent and reasons for maternal engagement in health service contacts focused on the well-being of the child as well as explanations given for child symptoms and behavior. When mothers were screened for depression during attendance at a well-baby clinic, significant associations were found between maternal depressive symptoms and maternal negative attributions about the child's speech, sleep and behavior **(SIA ET AL, 2013)**. A relationship has also been noted between maternal MHPs and attendance at emergency departments for non-critical conditions **(STOCK ET AL, 2013)**; non-attendance at well-baby appointments; poor uptake of childhood immunisations **(MINKOVITZ**

ET AL, 2005); and reduced adherence to recommended safety practices, such as the use of smoke alarms, car seats and the back to sleep position (BALBIERZ ET AL, 2015).

3.4.3.16. IMPACT OF MATERNAL MENTAL ILL-HEALTH ON MOTHER-INFANT AND FATHER-INFANT INTERACTIONS

Adverse outcomes for the child potentially accrue as a result of the reduced frequency and quality of mother-infant interactions. Mother-infant interaction difficulties consequent on maternal depression appear to be similar across cultures and socioeconomic circumstances (FIELD 2010). Mothers may either appear intrusive and hostile or passive and withdrawn (LOVEJOY ET AL, 2007). Mothers with MHPs have difficulty tuning in to their baby's needs and responding in a sensitive and reciprocal manner. A meta-analysis of 48 studies involving 4, 934 mother-infant dyads found a statistically significant dose-response relationship between maternal severity of depression and maternal sensitivity (BERNARD ET AL, 2018). The quality of maternal-infant interactions in structured, rather than unstructured, interactions are less likely to be adversely affected by maternal MHPs and are more likely to be sub-optimal when distressed mothers are exposed to stressful situations (GINSBURG ET AL, 2006; PSYCHOGIOU & PARRY, 2014).

Paternal-infant interactions are affected by paternal mental state and, independent of paternal mental state, may emulate characteristics of the maternal-infant interaction (PARFITT ET AL, 2013). For example, in a small study involving 45 families, the mental health of both parents affected the quality of their interaction with their infant and 10% of the interactions between both parents and the same infant were considered to be inept, or at risk, in terms of increasing the likelihood of child abuse or neglect (PARFITT ET AL, 2013). Fathers mental ill-health can have both an independent and synergistic impact on emotional and behavioural problems in children (GOODMAN, 2019). Non-depressed fathers may also attenuate the effect of maternal mental ill-health on child outcomes (GOODMAN, 2019). Hence the need to consider the health and well-being of the mother, the father, the infant and the relationships between them (GUTIERREZ-GALVE, 2015; GENTILE AND FUSCO, 2017).

3.4.3.17. IMPACT OF MATERNAL MENTAL ILL-HEALTH ON INFANT REGULATORY PROBLEMS.

Maternal MHPs can have an impact on both the perception and prevalence of regulatory problems in infancy (crying, sleeping, feeding) (GOLDBERG ET AL, 2013; MARTINI ET AL, 2017). An analysis of the data pertaining to over 11,000 mother-infant dyads in the ALSPAC study demonstrated an association between prenatal anxiety and depression and parent-reported sleep problems at 18 and 30 months (O'CONNOR ET AL, 2007). Frequent infant nocturnal wakings may also be the product of maternal anxiety, or the negative cognitive bias associated with depression, engendering a sense of inadequacy and need to check on and respond to the infant, even when the infant is not showing signs of distress (TETI & CROSBY, 2012).

3.4.3.18. IMPACT OF MATERNAL MENTAL ILL-HEALTH ON EMOTIONAL AND BEHAVIOURAL PROBLEMS IN CHILDREN.

Children of mothers with sub-threshold symptoms of depression during pregnancy or the first postnatal year are more likely to show signs of inattention, aggression, hyperactivity and separation anxiety at age three (KINGSTON ET AL, 2018) or emotional and behavioural problems at age 4 (GIALLO ET AL, 2015) (see section 3.6.1.4.) The Wirral Child Health and Development longitudinal study following the impact of maternal socioeconomic circumstances on behavior in 759 children found that children living in the most disadvantaged households scored 45% higher for externalizing problems than those living in the least disadvantaged households: 40% of this increased prevalence was attributable to maternal MHPs (RUTHERFORD ET AL, 2019).

Disruptive behavior has a knock-on effect on peer relationships and academic achievement as it is the most common reason for exclusions from school. Between 2009/2010 and 2013/2014, there was a 60% increase in the number of school exclusions of children aged 3 – 7 **(CORAM CHILDREN'S CENTRE, 2016)**. According to data from the UK millennium cohort study (n=12,000+) 48.7% of 7 year old children self-reported being bullied. Factors associated with increased risk included poverty and maternal mental ill-health **(CAMPBELL ET AL, 2017)**.

3.4.3.19. IMPACT OF MATERNAL MENTAL ILL-HEALTH ON ACCIDENTAL INJURIES IN CHILDREN

Evidence suggesting a link between maternal MHPs and accidental injuries in pre-school children is provided by a prospective cohort study of 207, 048 mother-child pairs in England with linked primary care and hospitalisation data from the Clinical Practice Research Datalink and Hospital Episode statistics. Between 1988 – 2013 maternal depression and/or anxiety episodes were associated with increased rates of child poisonings, fractures and burns during the first four years of a child's life **(BAKER ET AL, 2017)**. The three most common causes of hospital admissions in the under 5's are falls, poisonings, burns and scalds with an estimated annual cost to the NHS of 37 million pounds **(PHE, 2018 B)**. It has been hypothesized that depressed mothers provide inadequate levels of supervision and underestimate the risks of potential hazards **(PHELAN ET AL, 2014)**. The aforementioned prospective cohort study **(BAKER ET AL, 2017)** does not confirm a causal link between maternal MHPs and childhood accidents. Additional evidence is provided by confirmation of the association between maternal distress and maternal reports of increased episodes of unintentional injuries to their offspring at 3-5 years of age, derived from the UK millennium cohort study (n = 9,240) **(HOPE ET AL, 2019)**. This evidence indicates another potential adverse outcome for the child that could potentially be mitigated by both treating maternal MHPs and sensitively addressing child safety issues with mothers at risk of, or experiencing, MHPs.

3.4.3.20. IMPACT OF MATERNAL MENTAL ILL-HEALTH ON CHILD ABUSE AND NEGLECT

In extreme cases the impact of maternal mental ill-health on caregiving capacity can culminate in child abuse or neglect. In an analysis of 175/293 serious case reviews notified to Ofsted between 1st April 2011 and 31st March 2014, 53% of the cases featured parental MHPs. 120 of the 293 children (41%) were aged under 1 year at the time of their death or incident of serious harm **(SIDEBOTHAM ET AL, 2016)**. This emphasises the potential and serious risk to infants of untreated parental MHPs during the first year of life.

In a prospective cohort study involving 103 mother-offspring pairs, adult offspring were 2.4 times more likely to have experienced maltreatment as a child and 3.4 times more likely to have a depressive disorder as an adult if their mother suffered from antenatal depression **(PLANT ET AL, 2015)**. A systematic review of 35 studies involving 26,239 participants found 'robust trends of association' between childhood maltreatment and subsequent perinatal depression and PTSD when the child becomes an adult **(CHOI & SIKKEMA, 2016 P.427)**. This association was mediated by later victimisation and moderated by protective early relationships **(CHOI & SIKKEMA, 2016)**. Another systematic review based on 45,723 mother-child dyads from 12 studies found that the association between the mother's maltreatment as a child and emotional and behavioural problems in her own children was mediated by maternal psychological difficulties and compromised parenting **(PLANT ET AL, 2018)**. Analysis of data from the national psychiatric morbidity survey for England found that 54 % of women who experienced extensive physical or sexual abuse as both a child and an adult had a diagnosable mental illness, 21% experienced homelessness, 31% had an alcohol problem and 8% had a drug problem **(MCMANUS ET AL, 2016B)**.

Adult depression arising from childhood maltreatment is likely to be chronic, recurrent and difficult to treat **(NANNI ET AL, 2012; AMMERMAN ET AL, 2016)**. If the cycle of disadvantage perpetuated by intergenerational transmission of both child maltreatment and adult depression is to be broken, comprehensive and sensitive assessment of maternal mental health, and the implications for caregiving, is required, to ensure that timely and appropriate interventions are offered.

3.4.3.21. IMPACT OF MATERNAL MENTAL ILL-HEALTH ON CHILD DEVELOPMENT

Depressed mothers are less likely to play with, talk and sing to, smile at, and touch their babies in an affectionate manner compared to non-depressed mothers **(PAULSON ET AL, 2006; FIELD, 2010; COLEGROVE & HAVIGHURST, 2017)**. Depressed mothers are likely to appraise negative facial expressions in their infant more negatively than non-depressed mothers and less likely to accurately identify infant happy faces compared to controls **(STEIN ET AL, 2010; ARTECHE ET AL, 2011)**. Lack of maternal emotional availability combined with reduced motivation and opportunities for interaction can lead to deficits in the child's social, emotional, cognitive and physical development.

A Canadian longitudinal population-based cohort study, comparing medical record entries indicating maternal depression and anxiety disorders (MDAD) with child development outcomes measured using the Early Development Instrument at school entry for 18,331 mother-child dyads, found that cumulative exposure to MDAD was significantly negatively associated with all five areas of development (physical health and well-being; social competence; emotional maturity; language and cognitive development; and communication skills and general knowledge). The authors also noted that family context had a much stronger relationship with child outcomes than MDAD **(COMASKEY ET AL, 2017)**, again emphasising that there are multiple factors that exacerbate the impact of maternal MHPs on child outcomes.

The effect on cognitive development is not just to do with the impact of maternal MHPs on caregiving as longitudinal studies also indicate the adverse impact of antenatal stress, anxiety and depression on developmental outcomes. A longitudinal Scandinavian study involving 2,231 mothers found that fine and gross motor, communication, problem solving, and personal/social skills of pre-school children exposed to maternal depression during pregnancy, or the first postnatal year, were adversely affected **(TUOVINEN ET AL, 2018)**. The children of mothers with the most chronic and severe depressive symptoms during pregnancy had the worst developmental outcomes **(TUOVINEN ET AL, 2018)**.

The nature and extent of the impact on the foetus depends on the timing, severity, duration and physiological correlates of maternal symptoms **(ENTRINGER ET AL, 2015)**. In a prospective longitudinal study involving 35 mother-child dyads it has been demonstrated that children of mothers who experienced high levels of maternal anxiety during the second trimester (taking into account potentially confounding variables) had reductions in gray matter volume in prefrontal cortical regions of their brain when assessed with an MRI scan between 6 and 9 years of age **(BUSS ET AL, 2010)**. A study involving 81 mother-infant dyads revealed significant cortical thinning in the brains of 6-9 year olds whose mothers were depressed at 25 weeks gestation **(SANDMAN ET AL, 2015)**. Both reductions in gray matter volume and cortical thinning are associated with compromised cognitive development **(ENTRINGER ET AL, 2015)**. These are just two examples of the mechanisms whereby maternal physiological changes are implicated in the biological embedding of early adversity **(FOR A MORE DETAILED EXPLANATION SEE LEWIS ET AL 2015; HEIM ET AL, 2018; MEANEY, 2018)**. Other biological systems in the infant that could be adversely affected by perturbations in the early nurturing environment include the stress and immune systems, the gut microbiome and telomere biology **(VAN DEN BERGH ET AL, 2017)**.

A systematic review of 21 longitudinal studies from 8 high-income countries assessing the impact of maternal perinatal distress on developmental outcomes in school-aged children found convincing evidence of the effect of prenatal distress, and less compelling evidence for the effect of postnatal distress, on global development, behavior and socio-emotional development of children aged 48 months + - 8 years **(KINGSTON & TOUGH, 2014)**.

The health profile for England states that 29.3% of children are failing to reach a good level of development by the end of their first academic year **(PHE, 2018 C)**. Greater attention to the identification and treatment of perinatal MHPs, as well as the factors that exacerbate the risk, might help to reduce the number of children starting school with compromised development.

3.4.3.22. IMPACT OF MATERNAL MENTAL ILL-HEALTH ON CHILD PHYSICAL HEALTH

The long-term effects of maternal prenatal stress on physical health of offspring are illustrated by a retrospective case control study exploring the impact of maternal stress in pregnancy on pre-disease physiological markers in the progeny of those mothers when they were young adults (n=36). Although the young adults were considered healthy at the time the measurements were taken, compared to matched controls (n=22), they were significantly more likely to have higher BMI, be insulin-resistant, have a metabolic profile indicative of metabolic disease, altered immune function consistent with increased risk of asthma and autoimmune disorders and impaired cognitive performance consistent with stress-related changes in the pre-frontal cortex **(ENTRINGER ET AL, 2015)**.

Further evidence to illustrate the connection between maternal MHPs and childhood immune system function is provided by both cross-sectional analysis of population level data and longitudinal cohort studies. Data derived from 255 General Practices in the U.K, with access to the records of 3.9 million patients found that the children of mothers with a medical diagnosis of depression during pregnancy or the first six months after childbirth had a 40% increased rate of gastro-intestinal infections and a 27% increased rate of lower respiratory tract infections throughout the first four years of a child's life compared to children born to women without perinatal depression **(BAN ET AL, 2010)**. A longitudinal birth cohort study of over 2,000 Czech families suggests that stress during pregnancy or the first six postnatal months is linked to an increased susceptibility to infectious diseases in children aged 7 – 11 **(STEPANIKOVA ET AL, 2018)**. The cost to the NHS of treating gastrointestinal infections, lower respiratory tract infections and acute otitis media during the first year of life was estimated at £75.5 million in 2009 **(POKHREL ET AL, 2015)**.

A recent systematic review and meta-analysis including 6 studies, involving 170,371 children, found an association between prenatal/postnatal depressive symptoms or depression and hospitalisation or mortality in children up to one year of age **(JACQUES ET AL, 2019)**. The UK is ranked 15 out of 19 western European nations in terms of infant mortality **(RCPCH, 2017)**. It is possible that earlier and better recognition of maternal stress, anxiety and depression during pregnancy might reduce the likelihood of subsequent infant infections and avoidable deaths.

Breastfeeding confers many benefits. One of them is protection against childhood infections **(PAINE & QUIGLEY, 2016)**. An economic analysis in 2015 predicted that supporting mothers who were exclusively breastfeeding at 1 week (and wanted to continue) to continue exclusive breastfeeding until their child was 4 months old would result in reduced infant infections, less admissions to hospital and a saving to the NHS of £11 million/year based on 2009 costs **(POKHREL ET AL, 2015)**.

Some studies suggest a bidirectional relationship between maternal MHPs and breastfeeding initiation and duration (BORRA ET AL, 2015; DIAS & FIGUEIREDO, 2015). A longitudinal cohort study involving 584 mothers demonstrated a significant relationship between EPDS scores greater than 12 at 1 week postpartum and dissatisfaction/difficulty with breastfeeding and discontinuation at 4 or 8 weeks postpartum (DENNIS & MCQUEEN, 2007). Systematic reviews investigating the relationship between maternal MHPs and infant feeding outcomes found lower rates of initiation and/or maintenance of breastfeeding (DENNIS & MCQUEEN, 2009; COOKE ET AL, 2017; GRIGOURIADIS ET AL, 2018). Maternal mental health problems can cause physiological changes that influence the production of breastmilk (FALLON ET AL, 2016B). Even though mothers experiencing psychological distress may want to breast feed their baby (COATES, AYERS, DE VISSER, 2014) they may experience difficulties triggered by the physiological repercussions of their emotional state. Cessation of breastfeeding may lead to increased feelings of guilt and worry and amplified symptoms of anxiety and depression (DIAS & FIGUEIREDO, 2015).

Maternal MHPs have therefore been implicated with cessation of breastfeeding and increased risk of infant infectious diseases. It may be that prompt identification and support for mothers with MHPs as well as those experiencing difficulty breastfeeding will reduce hospital admissions due to infant infections, representing a considerable saving to the public purse.

3.4.3.23. IMPACT OF MATERNAL MENTAL ILL-HEALTH ON CHILDHOOD OBESITY

With regard to the relationship between maternal stress during pregnancy and subsequent childhood obesity it has been shown that increased maternal stress in the third trimester associated with higher concentrations of maternal cortisol culminates in a greater change in percentage body fat in infants between the ages of 1 and 6 months (ENTRINGER ET AL, 2015). This physiological predisposition to obesity is further exacerbated by maternal infant feeding practices. In a study involving 1,447 American mother-infant dyads, mothers with PPD were more likely to breastfeed at low intensity at 2 months, more likely to add cereal to their baby's bottle and more likely to introduce solid food before 4 months. Babies of these mothers had higher average weight gain during the first 6 months of life (GAFFNEY ET AL, 2014). A meta-analysis, involving over 47,000 children from six countries found that greater weight gain during the first year of life was consistently associated with increased risk for later obesity (DRUET ET AL, 2011). Weighted estimates for over 3 million children based on 42,239 caregivers across the U.S.A. found an association between adverse family experiences (excluding income, education and employment) during childhood, and adolescent obesity (HEERMAN ET AL, 2016). Parental mental ill-health is one of the possible 9 adverse family experiences responsible for this association.

In England, 22.6% of children are overweight or obese during their first year in school (PHE, 2018C). A strategy for combating obesity could begin with identifying and supporting mothers experiencing stress, anxiety and depression during pregnancy. Support for mothers to continue breastfeeding and commence complementary feeding should acknowledge the contribution of maternal mental health to healthy feeding practices and childhood obesity.

3.5. Conclusions

The prevalence of perinatal mental health problems confirms that maternal MHPs are a global issue although it is difficult to be entirely accurate about prevalence because of the different methods of assessment and different cut-off points on self-assessment tools used to signify 'caseness' or severity of illness. Apart from the stigma associated with mental illness that potentially inhibits disclosure, the complexity of assessing maternal mental health is further complicated by co-morbidities, difficulties in differentiating mental illness from physical illness or trauma, intimate partner violence, substance misuse, somatisation and symptoms normally associated with the transition to parenthood. Some symptoms are significant on their own and symptom clusters that do not reach the threshold for a diagnosis may still affect the mother's quality of life and relationships with others, or subsequently develop into a mental illness.

There is a very extensive literature on the impact of maternal MHPs on the developing child that can result in adverse outcomes that last a lifetime. Evidence from cross-sectional surveys highlights the relationship between maternal mental health and multiple aspects of development and nearly every facet of maternal care. Specific reference has been made to breastfeeding; nutrition and healthy weight; minor illnesses and accidents; and school readiness. Alongside transition to parenthood and maternal mental health these are the six high impact areas designated by Public Health England (and agreed by the Local Government Association) as areas where health visitors can make a significant difference to child and family outcomes **(PHE, 2018 D)**. However, the evidence included in this section is generally not used to accentuate or justify the need for investment in early intervention and prevention, and more specifically, the part that HVs could play in ameliorating the impact and cost of maternal MHPs. In many cases the mediating or moderating variables are not fully known so it is difficult to be explicit about cause and effect. This adds complexity to the assessment of maternal mental health and the rationale for, and focus of, appropriate interventions.

The purpose of the detailed investigation of prevalence and impact of maternal MHPs was to determine the size of the problem that LVs might be able to address. It is clear that maternal mental health is a complex and significant public health issue and the identification of mothers who might need help is complicated by all sorts of factors. The exclusive focus on anxiety and depression of most primary care based assessments needs to be extended so that mothers with other symptoms can be identified. It might be beneficial if comprehensive assessments of maternal mental health were offered to mothers on more frequent occasions throughout the perinatal period. These assessments should explore the range of determinants, symptoms and impact of maternal and infant distress so that responsive interventions can be offered. Interventions need to be tailored to maternal symptoms, preferences and circumstances and include consideration of maternal caregiving capacity and the mother-infant relationship. All these elements could be included in an intervention offered by HVs that may, or may not, be described as LVs.

3.6. Chapter summary

Despite the volume of literature that was reviewed in the three investigations described in this chapter, my impression is that I am still only just scratching the surface of all there is to know that might be worthy of consideration, in the context of what HVs do to support mothers with MHPs. It would seem that despite the fact that NICE acknowledges that there may be problems with the methodology underpinning their deliberations and that recommendations in guidelines are not mandatory (especially if the wording invites readers of the guideline to 'consider' taking action), the act of omission can have a powerful effect on practice. The attempt to find a unifying definition of LVs exacerbated rather than appeased the underlying confusion about what they are, and exposed various aspects of training and delivery that undermine competence and sap confidence. A review of the prevalence and impact of maternal MHPs affirms the difficulties in determining who needs help and builds a strong case for improving the assessment and support offered to mothers experiencing any form of psychological distress in the perinatal period. The solution to the issues identified probably extends beyond the role of the HV, but it is possible that this evidence could be used to create a clearer expectation of what HVs could do, within an integrated and collaborative pathway of care, and provides robust justification of the need to improve the availability of good quality training and supervision.

Chapter 4. Identifying the Evidence Base

4.1. Introduction

Some evidence has been presented in the previous chapter to indicate that the prevalence and impact of maternal MHPs extend beyond PND and potentially have far-reaching and long-lasting impacts. It has also been suggested that there needs to be a better system in place to enable prompt identification and treatment of mothers who may present with a range of symptoms that may not be detectable with conventional assessment tools. Treatments need to incorporate strategies that address multiple aspects of the maternal environment, including the mother-infant relationship.

LVs, originally developed as a therapeutic intervention for HVs to offer to mothers with PND, have been adapted over time in response to changes in knowledge about the range of perinatal MHPs, the treatments that might be effective and constraints imposed on HVs by aspects of the working environment. Literature reviews, reported in the previous chapter, have highlighted some issues around variations in the content and purpose of the intervention and the competence and confidence of HVs to deliver LVs.

When the Bleijenberg et al (2018) enriched development phase of the MRC guidance was introduced in chapter 1 the point was made that the research process would be guided by the stages of the framework, but that the order in which the research was presented might not reflect the order in which the research was done. This stage, identifying the evidence base, was completed after the stage reported in chapter 7, examining current practice and context. The method deployed in Chapter 7 was a survey of HVs. One of the findings from that survey was that many of the respondents echoed the findings from the literature, regarding HV perceptions of variations in LV practice, and wanted an updated, evidence-informed manual to guide their practice.

As it has been suggested that LVs might not be the most appropriate intervention to treat mothers with MHPs, the question is 'What should HVs be doing to support mothers with MHPs?' or 'What additional components could be added to LVs to make them more responsive and effective? The first part of a two-part method chosen to answer these questions was a 'rapid review'. The second part is the use of the Distillation and Matching Model (DMM) developed by Chorpita et al (2005) to identify the common elements and key implementation processes of effective interventions.

A rapid review is a streamlined version of a systematic review and has been described as a useful approach 'to providing actionable and relevant evidence in a timely and cost-effective manner' **(TRICCO ET AL, 2017,P.XIII)**. Effective delivery of evidence-based interventions requires a clear understanding of what the intervention is, how it is meant to work and how it should be delivered. The problem is that the best quality evidence is derived from systematic reviews and meta-analyses that have combined the findings from randomized controlled trials (RCTs). The interventions described in each of those trials may not be exactly the same or may not be described in sufficient detail to facilitate replication or confer similar beneficial outcomes. Significant heterogeneity can occur at multiple levels of delivery such as context, location, characteristics of providers and recipients, components and expected/ measured outcomes of the intervention **(KÖPKE ET AL, 2015)**.

It has been suggested that instead of focussing on a specific treatment for a specific psychological problem it might be useful to identify the active ingredients of effective interventions in order to design a composite treatment of common elements that could improve outcomes for multiple, and often, co-morbid disorders **(ENGLAND ET AL, 2015; MURRAY ET AL, 2014)**. The DMM (**CHORPITA ET AL, 2005**) is

the method used to identify, extract and compare the common elements of the effective interventions identified in the rapid review.

The method and results for conducting both these aspects of the investigation (rapid review and DMM) will be reportedly separately prior to an integrated discussion of the findings and consideration of the implications of this stage of the research in the context of both previous and future stages of the research.

4.2. Method for rapid review

This rapid review is based on guidance issued by the World Health Organisation (WHO) **(TRICCO ET AL, 2017)** and involved the following steps: protocol development using the PICOS format (Table 4.1); a database search of a limited number of databases (Tables 4.2 & 4.3); a 2-stage search process commencing with the identification of existing systematic reviews, followed by screening and selection of relevant primary studies; the use of PRISMA reporting items to guide protocol development (Fig 4.1); systematic data extraction limited to key study characteristics and outcomes (Table 4.4); risk of bias or quality assessment (Tables 4.5. and 4.6.); knowledge synthesis presented in the form of a narrative summary.

TABLE 4.1. PICOS CRITERIA FOR SEARCH STRATEGY TO IDENTIFY EFFECTIVE INTERVENTIONS, DELIVERED BY NON-MENTAL HEALTH SPECIALISTS, TO COMMUNITY-BASED MOTHERS EXPERIENCING PERINATAL

POPULATION OF INTEREST	Mothers at risk of, or suffering from, symptoms indicative of common mental health problems during pregnancy or the first postpartum year.
INTERVENTION	Any intervention delivered by non-mental health specialists to treat perinatal MHPs in community-based mothers.
COMPARISON	No intervention or usual care.
OUTCOMES	Primary outcome measures: Reduction in symptoms. Secondary outcome measures: Improvements in mother-infant relationships, parenting capacity, child health and development.
STUDIES	Inclusion criteria: Peer-reviewed articles describing RCTs, quasi-experimental studies demonstrating the effectiveness of the intervention, written in English, reported 2009 – 2019*, delivered by non-mental health specialists. Prospective studies and open trials included if they provide details about the active ingredients of an intervention delivered by non-mental health specialists and provide evidence of beneficial outcomes for mothers, partners and babies. Pilot studies included if they have comparable sample sizes to the included RCTs and are of sufficiently robust methodological quality. Exclusion criteria: Studies reporting interventions for mothers with more serious MHPs such as bipolar disorder or psychosis. Interventions delivered in a group format. Interventions that were not effective in reducing symptoms of MHPs. Studies that were not directed at improving maternal mental health/ did not include assessment of symptoms as an outcome measure.

*Time frame chosen based on the assumption that the PONDeR trial **(MORRELL ET AL, 2009)** will have stimulated thinking and research about alternative interventions delivered by non-mental health specialist that might be effective in treating mothers with perinatal MHPs.

As it is acceptable in a rapid review to limit the search of the literature to a limited number of databases, the searches were initially focused on the CINAHL and Medline databases. Although the Pubmed database encompasses medline, it also includes 'in-process' and 'ahead-of-print' citations (that may not be catalogued using MESH headings) so an additional search was conducted using Pubmed to see if a greater number of relevant articles might be identified using this database.

Articles in medline are catalogued using the MESH (Medical Subject Headings index) so only articles with heading included in the index will be retrieved. The CINAHL database also has its own thesaurus of subject headings. Some articles are linked to key words that are not included in either the MESH index or the CINAHL thesaurus (miscellaneous search terms). As an experiment, I wanted to find out how many relevant articles might be retrieved by using the MESH search terms, the CINAHL search terms and the miscellaneous search terms with each of the three databases.

TABLE 4.2. DATABASES AND SEARCH TERMS USED TO IDENTIFY ARTICLES DESCRIBING EFFECTIVE INTERVENTIONS, DELIVERED BY NON-MENTAL HEALTH SPECIALISTS, TO COMMUNITY-BASED MOTHERS EXPERIENCING PERINATAL MHPS

Search terms		
MESH terms	CINAHL subject headings	Miscellaneous search terms
Perinatal/peripartum/postnatal/ postpartum/antenatal/antepartum/ pregnancy/prenatal **AND** Depress*/depressive symptoms/ depressive disorder/mood disorders/ anxiety/anxiety disorders/trauma and stressor related disorders/stress, psychological/adjustment disorder/ mental health **AND** Health visitor/nurses, community health/ nurses, public health/visiting nurses/ home health nurses/home nurses/ community health workers not (psychiatric nurs*/psychologist/ physician/psychiatrist) **AND** Psychotherapy/counseling/directive counseling/problem solving/self care/self management/psychology/social support/ health promotion/preventive medicine **AND** Systematic review/Clinical trials or randomized controlled trials/therapeutic trials/intervention trials/therapeutic trials /pilot study	Pregnancy/prenatal care/Postnatal period /postnatal care **AND** Depression/Depression, postpartum/ affective symptoms/affective disorders/ emotions/anxiety/anxiety disorders/ stress/adjustment disorder/diagnosis, psychosocial/psychosocial aspects of illness **AND** Community health nursing/community health workers/home visits/maternal-child nursing **AND** Nursing interventions/Support, psychosocial/psychotherapy/ cognitive therapy/counselling/preventive healthcare/health promotion **AND** Systematic review/Clinical trials/ randomized controlled trials/therapeutic trials/intervention trials/therapeutic trials/pilot study	Perinatal/peripartum/postnatal/ postpartum/antenatal/antepartum/ pregnancy/prenatal **AND** Depression/anxiety/mental health/ common mental health problems/ psychological problems/stress/distress/ adjustment disorder **AND** Health visitor/public health nurse/ specialist community public health nurse /community nurse/community health nurse/child and family health nurse/ child health worker/non- mental health specialist/maternity and child health worker/outreach worker/family support worker **AND** Intervention/treatment/management/ strategy/support/prevention/promotion/ practice/therapy/counseling/approach/ self-help **AND** Systematic review/Clinical trials/ randomized controlled trials/therapeutic trials/intervention trials/therapeutic trials/pilot study
Databases: No of articles identified CINAHL		
11 selected articles = 3	38 selected articles = 11	285 selected articles = 40
Databases: No of articles identified Medline		
24 selected articles = 4	12 selected articles = 2	17 selected articles = 2
Databases: No. of articles identified PubMed		
124 selected articles = 20	124 selected articles = 20	109 selected articles = 22
Databases: Total records identified		
159	164	411

4.3. Results for rapid review

The WHO rapid reviews guidance states that searches can be limited to 2 databases. The search of PubMed was added just to see how it compared to searches of CINAHL and Medline databases using MESH, CINAHL or key words linked to relevant articles already identified during the hermeneutic literature review (miscellaneous search terms). The most successful search strategy appeared to be a combination of the miscellaneous search terms and the CINAHL database. The maximum number of articles retrieved by searches of all three databases using the miscellaneous search terms was 411. These articles are used as the starting point for the selection of articles that meet the PICOS criteria. The process of selection of the final 20 articles is summarised in the PRISMA flow chart (Fig 4.1)

As the purpose of rapid reviews is to follow a transparent and robust process to find the appropriate information of suitable quality, it is considered advisable to commence the process by searching for existing systematic reviews. At the very least this will provide useful background information and, at best, may provide the level and quality of evidence that is needed for the rapid review.

40 systematic reviews were identified. Between 3 and 130 studies were included in each of the systematic reviews. 2 reviews were reviews of reviews. Each of these summarised the findings from 32 systematic reviews. Some systematic reviews included both qualitative and quantitative studies. In some cases, the same primary studies were included in different systematic reviews. The small sample size of some RCTs, poor design, unclear risk of bias, low quality studies or heterogeneity of included studies meant that many of the systematic reviewers were unable to draw any firm conclusions or make any specific recommendations as a result of their analysis.

Each systematic review was 'carefully' re-viewed to see if any of the included studies met the criteria for this rapid review. 7 primary studies were identified in this way and were added to the potentially relevant studies identified in the database searches. The PRISMA flow chart indicates the process for identifying the final 20 articles that were included in the narrative summary, although one of these is counted twice as it was a three arm trial where the outcomes for both intervention groups (one involving a person-centred approach and one involving a cognitive behavioural approach) were slightly better than those for the control group. **(MORRELL ET AL, 2009)**. A summary of key study characteristics and outcomes of the final 20 primary studies are presented in table 4.3. Ten of the studies took place in the U.S.A, 3 in Australia, 3 in the UK, and 1 each in Norway, India, Israel and South Africa. More in-depth detail about the 20 included studies will be provided in the next section of this chapter when the Distillation and Matching Model will be used to identify the commonly occurring elements of these interventions.

The Critical Appraisal Skills Programme (CASP) quality appraisal checklist for RCTs was used to evaluate the quality of the studies **(CASP, 2018)** (Tables 4.4. and 4.5.), whilst acknowledging the particular challenges of applying the criteria to perinatal mental health interventions. These include: the impossibility of 'blinding' providers and recipients of talking therapies; inadequate descriptions of 'treatment as usual', or similarity with the intervention, reducing the observable difference in effect; variations in outcomes assessed and outcome measures used (self-report/ clinical interview); the use of depression scores as dichotomous rather than continuous variables; high rates of attrition; cultural variations in health system organization, professional roles and responsibilities; and different interpretations of causes, symptoms and risk.

The partially supported CASP criteria are those relating to the similarities of the groups at baseline, the 'blinding' of researchers and participants, and the consideration of all clinically relevant outcomes. Despite randomization there was sometimes a skewed predominance of a particular characteristic in the baseline demographic data, although attempts were usually made to account for this in the analysis. Reference has already been made to the impossibility of 'blinding' participants receiving 'talking therapies' to the intervention they were receiving. With regard to outcomes, given the complexities of disadvantaged populations, there may have been other outcomes that it would have been useful to measure that might have had a bearing on response to treatment (e.g. intimate partner violence). The quality issues identified are not of sufficient concern to necessitate excluding any of the interventions from the next phase of analysis, which is to identify, extract and tabulate the commonly occurring elements of these 20 effective interventions.

FIGURE 4.1. PRISMA FLOW CHART INDICATING SELECTION OF ARTICLES FROM RAPID REVIEW OF EFFECTIVE INTERVENTIONS FOR MOTHERS WITH MENTAL HEALTH PROBLEMS DELIVERED BY NON-MENTAL HEALTH SPECIALISTS

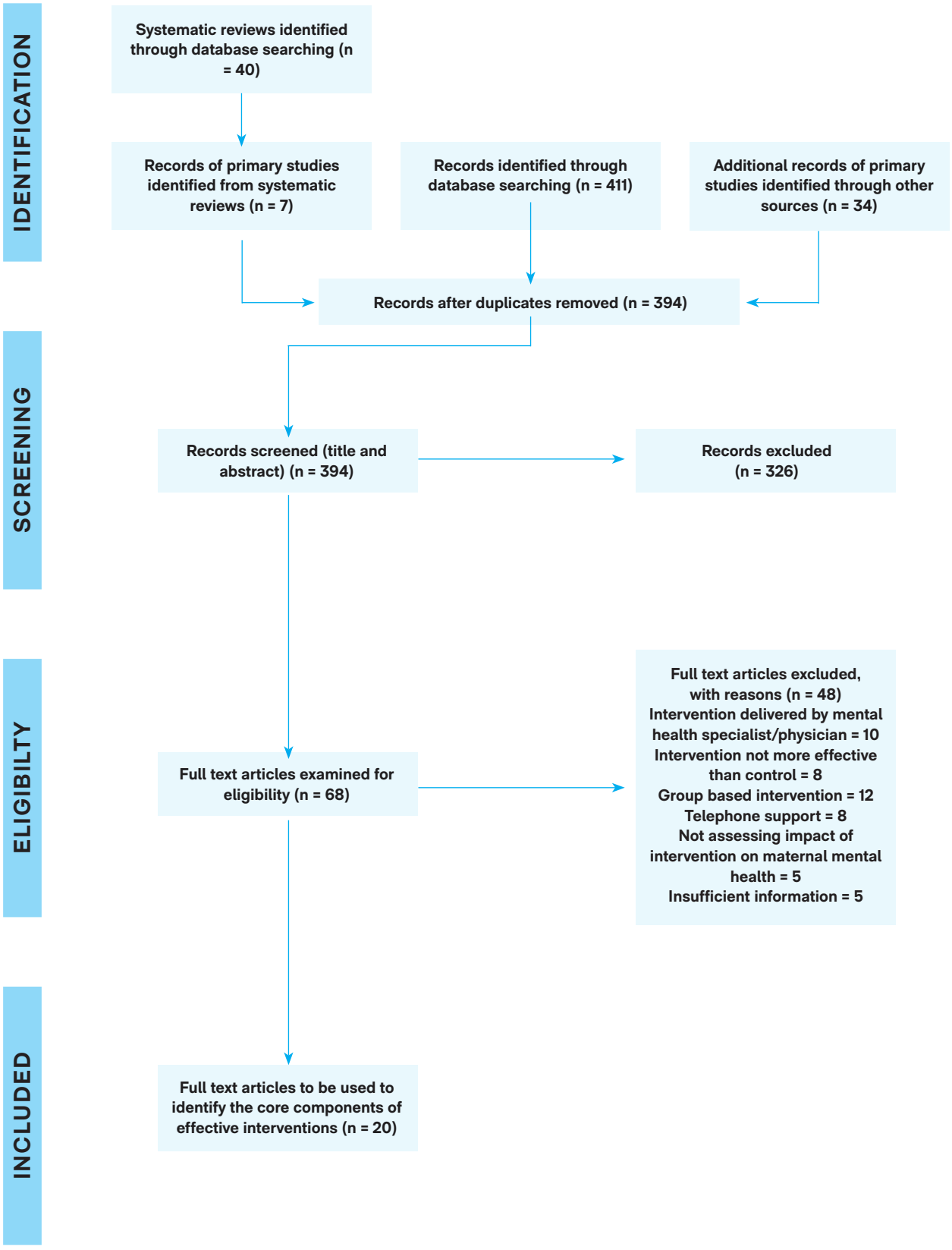


TABLE 4.4. KEY STUDY CHARACTERISTICS AND OUTCOMES OF PRIMARY STUDIES DESCRIBING EFFECTIVE INTERVENTIONS, DELIVERED BY NON-MENTAL HEALTH SPECIALISTS, TO COMMUNITY-BASED MOTHERS EXPERIENCING PERINATAL MHPS

2009

STUDY DETAILS Cooper PJ, Tomlinson M, Swartz L, Landman M, Molteno C, Stein A, ...Murray, L (2009). Improving quality of mother-infant relationship and infant attachment in socioeconomically deprived community in South Africa: Randomized controlled trial. Br Med J 338: b974.
COUNTRY South Africa
SUMMARY OF FINDINGS 449 pregnant women recruited during last trimester of pregnancy were randomised to receive an intervention to improve maternal-infant interaction plus usual care or usual care. The intervention group mothers received a total of 16 sessions (from pregnancy to 5 months postpartum) from a local mother who had been trained over a period of 4 months in basic parenting and counselling skills. The intervention group mothers showed increased maternal sensitivity (small effect size) at 6 months, sustained at 12 months postpartum, compared with control group mothers. Infants of intervention group mothers were also more likely to be securely attached when assessed with The Strange situation at 18 months.

2009

STUDY DETAILS Morrell CJ, Warner R, Slade P, Dixon S, Walter S, Paley G, Brugha T (2009) Psychological interventions for PND: Cluster Randomised trial and economic evaluation: The PoNDER trial. Health Technology Assessment 13 (37): 1 – 176 (counted twice to acknowledge the two intervention arms of the study).
COUNTRY UK
SUMMARY OF FINDINGS 595 mothers with an EPDS score of 12+ received a psychological intervention based on either a cognitive behavioural approach or a person-centred approach delivered by HVs, or treatment as usual (according to the randomised cluster where they worked). The intervention consisted of 8x1 hr home visits (IG). The effectiveness of the intervention was assessed by repeat EPDS at 6 months postpartum. 45.6% of control group women (treatment as usual) had EPDS score of 12+ at 6 months postpartum compared with 33.9% of IG women. This represents a statistically significant but clinically small effect of the intervention.

2009

STUDY DETAILS Roman LA, Gardiner JC, Lindsay JK, Moore JS, Luo Z, Baer LJ, … Paneth N. (2009). Alleviating perinatal depressive symptoms and stress: a nurse-community health worker randomized trial. Archives of Women's Mental Health, 12(6), 379–391. https://doi.org/10.1007/s00737-009-0083-4
COUNTRY U.S.A.
SUMMARY OF FINDINGS 613 pregnant women, recruited at less than 24 weeks gestation and scoring 16+ on the Centre for Epidemiological Studies Depression Scale were randomised to receive state sponsored, universally available, community-focused, enhanced perinatal services provided by professionals (usually a nurse) or to a enhanced version of the programme provided by a nurse – community health worker (CHW) team incorporating additional strategies to address depressive symptoms and stress (intervention group). The nurse led the team, provided case management and crisis intervention, supported the CHW and had a minimum of 5 face-to-face contacts with mothers during pregnancy and the first postpartum year. The CHW's completed a face-to-face contact every other week during pregnancy, weekly in the 8 weeks postpartum (if needed), then fortnightly until 6 months postpartum and then as required until 12 months postpartum. Women in the IG had significantly less

symptoms of depression at 15 months postnatally compared to mothers in the control group. The effect was more pronounced in mothers with high stress and low psychosocial resources.

2010

STUDY DETAILS Glavin K, Smith L, Sørum R, Ellefsen B. (2010) Supportive counselling by public health nurses for women with postpartum depression. J Adv Nurs. 66 (6) :1317–27. doi: 10.1111/j.1365-2648.2010.05263.x.

COUNTRY Norway

SUMMARY OF FINDINGS In a pragmatic trial involving 2 different municipalities (1 designated intervention, 1 designated control) 64 postpartum mothers in the control group and 164 in the intervention group scored 10+ on the EPDS at a routine screening assessment at 6 weeks postpartum. Mothers in the intervention group were offered a 2-part intervention by a PHN. All eligible women received 1 supportive counselling session to explore their preferences and needs and ascertain whether continuing support from the PHN would be appropriate. 34% (56/164) were offered further sessions and received between 2 and 7 sessions. The EPDS was repeated at 3 months and 6 months postpartum. Mothers in the intervention group showed a mean improvement of 5.9 points between the baseline EPDS and 6 month assessment vs a 3.4 point reduction in the control group indicating a statistically and clinically significant difference between the intervention and control group.

2011

STUDY DETAILS Milgrom J, Holt C, Gemmill A, Ericksen J, Leigh B, Buist A, Schembri C (2011a) Treating postnatal depressive symptoms in primary care: a randomised controlled trial of GP management, with and without adjunctive counselling. BMC Psychiatry 11: 95 doi: 10.1186/1471-244X-11-95

COUNTRY Australia

SUMMARY OF FINDINGS 68 mothers, with infants 16 weeks – 4 months, who scored 13+ on the EPDS, and diagnosed as depressed by their GP, were randomised to one of 3 groups: enhanced GP management (GPM) alone; enhanced GPM plus counselling from a nurse; OR Enhanced GPM plus counselling from a psychologist. Data collection at 8 weeks post-randomisation revealed that depression and anxiety symptoms were reduced in all groups. Some evidence that the counselling delivered by nurses was more effective than the counselling delivered by psychologists.

2011

STUDY DETAILS Milgrom J, Schembri C, Ericksen J, Ross J, Gemmill AW (2011b) Towards parenthood: an antenatal intervention to reduce depression, anxiety and parenting difficulties. J Affect Disorders 130 (3): 385 – 394. https://doi.org/10.1016/j.jad.2010.10.045

COUNTRY Australia

SUMMARY OF FINDINGS 143 women who were 20 – 32 weeks pregnant were recruited from 2 Melbourne hospitals if they scored 13 + on the EPDS or risk assessment checklist. They were stratified according to high or low screening scores to ensure comparable numbers of each in intervention and control groups. All participants' were given an information booklet about how to access community support and an information booklet about emotional health during pregnancy. GPs and other relevant health professionals were contacted and informed of all the other professionals involved in the woman's care to encourage collaborative case management. The 71 women allocated to the intervention group received a self-help workbook (Towards Parenthood) consisting of 8 units to be completed during pregnancy and 1 unit to be completed postpartum. Units covered preparation for parenthood, self-care,

managing role transitions, behavioural activation, cognitive strategies for dealing with depression and anxiety, developing realistic expectations about caring for a newborn baby. Women were able to discuss the content during the course of pre-arranged weekly 30 minute telephone calls with a psychologist/ trainee psychologist. Unit 2 was written specifically for fathers, so only one session was required to discuss units 2& 3 were discussed at the same session with the psychologist resulting in 8 possible telephone sessions. The postnatal unit was completed 6 weeks postbirth. Assessments were undertaken at baseline, pre-randomisation and 12 weeks post-partum. Significantly lower levels of depression and a trend towards reductions in parenting stress were reported in the intervention group at the 12 week assessment, compared with the controls.

2013

STUDY DETAILS Ammerman RT, Putnam FW, Altaye M, Stevens J, Teeters AR, Van Ginkel JB (2013) A clinical trial of in-home CBT for depressed mothers in home visitation. Behav Ther 44(3):359-372. Doi: 10.1016/j.beth.2013.01.002

COUNTRY U.S.A.

SUMMARY OF FINDINGS 93 depressed postpartum mothers were randomized to receive standard home visiting or home visiting + in-home CBT (IH-CBT). The intervention, tailored to the needs of young, low-income mothers, consisted of 15 weekly sessions + a booster 1 month post-treatment delivered by social workers. Parent enhancement components involving review of parental attributions about self and infant; helping mothers to interpret and respond to facial expressions, behavioural cues and circadian rhythms; and facilitating introduction of age-appropriate interactive activities were introduced in sessions 4 -9. The IH-CBT intervention involved close collaboration with the home visitor. Mothers receiving IH – CBT were significantly less likely to meet diagnostic criteria for depression at post-treatment assessment and 3 month follow-up. Mothers also reported improved functioning, increased social support, decreased psychological distress, increased ability to cope with stress linked to parenting and a more nurturing approach to parenting their children.

2013

STUDY DETAILS O'Mahen H, Himle JA, Fedock G, Henshaw E, Flynn H (2013a) A pilot randomized controlled trial of cognitive behavioral therapy for perinatal depression adapted for women with low incomes. Depression and Anxiety 30: 679-687

COUNTRY U.S.A.

SUMMARY OF FINDINGS 55 women recruited from 4 American obstetrics clinics, who met diagnostic criteria for major depressive disorder, were randomly assigned to modified CBT intervention (behavioural activation, cognitive restructuring) or treatment as usual. The intervention included an engagement session, specific perinatal content, emphasis on interpersonal issues and between session contact. The protocol specified up to 12 x50 minute sessions delivered by either a social worker or a psychologist. 73% of sessions were conducted in participant's homes. Women in the trial attended an average of 2.3 sessions antenatally and 5.35 sessions postnatally.60% of women completed more than 4 sessions. Therapists phoned participants an average of 3 times between sessions and rescheduled sessions an average of 3 times. Women in the intervention group had greater decreases in depressive symptoms, compared to women in the control group, at 16 weeks post-randomisation and at 3 month follow-up. Treatment adherence was associated with greater improvements in depressive symptoms.

2014

STUDY DETAILS O'Mahen HA, Richards DA, Woodford J, Wilkinson E, McGinley J, Taylor RS, Warren FC (2014). Netmums: a phase II randomized controlled trial of a guided Internet behavioural activation treatment for postpartum depression.Psychological Medicine 44(8): 1675–1689.
doi: 10.1017/S0033291713002092

COUNTRY U.K.

SUMMARY OF FINDINGS In the first study: Small to moderate effect for women who completed the course, but high rates of attrition (63%) **(O'MAHEN ET AL, 2013B)**. In the phase II RCT 249 mothers were recruited via the netmums website. 83 met criteria for major depressive disorder and were randomized to a supported, internet –based, modular intervention 'Helping with Depression,' or treatment as usual. Content from phase I was modified and a guided support component was added. The modules were based on the behavioral activation functional analytical framework **(ADDIS & MARTELL, 2004)**. The original 12 session course was reduced to a core module of 5 sessions with the option for mothers to choose 2 out of 6 further modules. Mothers received weekly phone calls from a supporter who had received 5 days of training in the perinatal-specific behavioural activation treatment. The average amount of therapist time per mother over the course of the intervention, was 253 mins. The EPDS was used to assess symptoms at baseline and at 17 weeks and 6 months post-treatment. 83% of women were retained at 17 week follow up. There was a clinically significant improvement in depressive symptoms in 62.2% (23/37) in the intervention group compared with 29.4% (10/34) in the control group.

2014

STUDY DETAILS Nugent JK , Bartlett JD , Valim C (2014).
Effects of an infant-focused relationship-based hospital and home visiting intervention on reducing symptoms of postpartum maternal depression. Infants & Young Children 27 (4):292–304. doi:10.1097/IYC.0000000000000017

COUNTRY U.S.A.

SUMMARY OF FINDINGS 106 first-time postpartum mothers were randomized to receive NBO prior to discharge from the maternity hospital and 1 month postpartum. The control mothers received routine hospital care PLUS 1 attention control home visit at 1 month for the purpose of administering the EPDS. The odds of developing depressive symptomatology when measured at 1 month postpartum using the EPDS were 75% less in the intervention group compared with controls.

2015

STUDY DETAILS Grote NK, Katon WJ, Russo JE, et al (2015) Collaborative care for perinatal depression in socio-economically disadvantaged women: a randomized trial. Depression and Anxiety 32:821–834, 2015

COUNTRY U.S.A.

SUMMARY OF FINDINGS 168 pregnant women between 12 – 32 weeks gestation who met criteria for probable major depression and/or dysthymia were randomised to either MOMCare or treatment as usual (that also involved enhanced identification and support for mothers who scored 10+ on the PHQ-9). MOMCare was based on the principles of collaborative care and IPT. A depression care specialist (DCS) (social worker with additional training) liaised with Maternity and Mental Health Services and women to ensure provision of appropriate care and facilitate access to other services. The DCS delivered the manualised intervention that included an engagement session, 8 sessions of brief IPT and maintenance sessions up to 1 year postpartum. Improvements in depressive symptoms and remission rates were observed in the intervention group compared to the control group.

2015

STUDY DETAILS Segre LS, Brock RL, O'Hara MW (2015). Depression treatment for impoverished mothers by point-of-care providers: A randomized controlled trial.Journal of consulting and clinical psychology, 83(2), 314–324. doi:10.1037/a0038495

COUNTRY U.S.A.

SUMMARY OF FINDINGS 66 women recruited from 4 sites were randomised to a 'Listening Visit' (LV) intervention or wait-list control group. The LV intervention consisted of 6 weekly home visits delivered by a home visitor who had received an additional 2 days of training. Within the LVs, home visitors used reflective listening and collaborative problem-solving to help the mother to generate her own solutions to improve her mood. 36% of the women in the LV group and 14% of women in the wait-list control group experienced clinically significant improvement in depressive symptoms from baseline to the 8 week assessment.

2015

STUDY DETAILS Goodman JH, Prager J, Goldstein R (2015) Perinatal dyadic psychotherapy for postpartum depression: a randomized controlled pilot trial. Arch Womens Ment Health. 18(3): 493–506. doi:10.1007/s00737-014-0483-y.

COUNTRY U.S.A.

SUMMARY OF FINDINGS 58 mothers who scored between 9 and 20 on the EPDS were assessed using the structured clinical interview to exclude those with bipolar disorder or current/ lifetime psychotic disorder. 42 mother-infant dyads were randomised to receive the perinatal dyadic psychotherapy intervention (intervention group) delivered by nurses or phone calls from the study co-ordinator emulating the frequency of the intervention home visits (control group). Depressive and anxiety symptoms in mothers in both the intervention and control groups showed similar improvement post-intervention and at 3 month follow-up. Maternal self-esteem and maternal responsiveness was also equally improved in both groups.

2016

STUDY DETAILS Zlotnick C, Tzilos G, Miller I, Seifer R, Stout R (2016). Randomized controlled trial to prevent postpartum depression in mothers on public assistance. Journal of Affective Disorders, 189, 263–268. https://doi.org/10.1016/j.jad.2015.09.059

COUNTRY U.S.A.

SUMMARY OF FINDINGS COUNTRY 205 pregnant women on public assistance in Providence, Rhode Island, identified as at risk of postpartum depression, were recruited between 20-35 weeks gestation and randomised to intervention+ standard care or standard care. The ROSE intervention (Reach Out, Stay Strong for mothers of newborns) consisted of 4 x 90 minute group sessions delivered over a 4-week period, by a non-mental health specialist, incorporating psychoeducation, development of skills for improving relationships and building networks of support in the context of managing the transition to parenthood. A 50 minute individual booster session was offered within 2 weeks of delivery. At 6 months postpartum, women in the intervention group were significantly less likely to develop PND than women in the control group. This intervention can be delivered on a 1-on-1 basis.

2016

STUDY DETAILS Sampson M, Villarreal Y, Rubin A (2016). A Problem-Solving Therapy (PST) Intervention for Low-Income, Pregnant Women at Risk for Postpartum Depression. Research on Social Work Practice 26(3): 236–242. https://doi.org/10.1177/1049731514551143

COUNTRY U.S.A.

SUMMARY OF FINDINGS COUNTRY Social workers received 1.5 days of training in Motivational Interviewing (MI) and Problem Solving Therapy (PST). Pregnant, low-income mothers who scored 9+ on the EPDS when recruited to the Healthy Start programme were invited to participate in a programme to learn about depression. 14 women agreed to participate in a pilot trial.The intervention was comprised of 1 MI session and 4 PST sessions. 'Each PST session included a progress update, topic discussion, and goal setting. Participants were asked to identify problems, brainstorm possible solutions, set goals, and come up with a specific action plan, to be carried out as "homework,"on how to solve the initially identified problems.' (Sampson et al. p.239.) This pilot study involving 14 mothers showed clinically and statistically significant differences between pre- and post-intervention EPDS scores. A 93% retention rate and 100% completion of homework demonstrated the acceptability of the intervention to mothers.

2016

STUDY DETAILS Glasser S , Hadad L, Bina R, Boyko V, Magnezi R (2016) Rate, risk factors and assessment of a counselling intervention for antenatal depression by public health nurses in an Israeli ultra-orthodox community. Journal of Advanced Nursing 00(0), 000–000. doi: 10.1111/jan.12938

COUNTRY Israel

SUMMARY OF FINDINGS 45 pregnant mothers at approximately 31 weeks gestation with EPDS scores greater than 10, or considered by the MCH clinic nurse to need additional help relating to risk factors or mental health issues, were offered Non-directive counseling. Topics discussed included 'women's thoughts and emotions, transition to parenthood, changes in life patterns and family relationships, organization of daily activities, problem-solving with a focus on jointly seeking solutions, and encouragement for positive changes. In this pre-test, post-test intervention study, only 1 woman scored 10+ on the EPDS at the 8 week postpartum assessment. Over a quarter of the mothers scored zero which makes it difficult to draw conclusions from the results. **(GLASSER ET AL, 2016 P.5).**

2017

STUDY DETAILS Holt C, Milgrom J, Gemmill AW (2017) Improving help-seeking for postnatal depression and anxiety: a cluster randomised controlled trial of motivational interviewing. Arch Womens Ment Health. https://doi.org/10.1007/s00737-017-0767-0

COUNTRY Australia

SUMMARY OF FINDINGS 40 Maternal and Child Health nurses invited all mothers seen at the universal 4 week post birth visit to participate in the study until each nurse had recruited a maximum of 20 women. 541 women were randomized to receive the intervention or routine care. The period prevalence of emotional distress across the first postnatal year was 27.4%. Approximately half of these mothers sought help. The purpose of the study was to see if training MCH nurses to use motivational interviewing techniques would increase the number of women seeking help. In the intervention group, 60.3% of women who were emotionally distressed sought help, compared with 35.4% in the control condition.

2018

STUDY DETAILS Tandon SD, Ward EA, Hamil JL, Jimenez C, Carter M (2018) Perinatal depression prevention through home visitation: a cluster randomized controlled trial of mothers and babies 1-on-1. J Behavioural Medicine. 41 (5): 641 – 652 10.1007/s10865-018-9934-7

COUNTRY U.S.A.

SUMMARY OF FINDINGS 128 women not experiencing major depression were enrolled to receive the Mothers-and-Babies group intervention adapted for delivery by trained home visitors to individual mothers. The intervention included 15 – 20 minute sessions added on to 12 routine home visits using the principles of CBT and attachment theory to help mothers to manage their internal (thoughts, hopes, feelings) and external (circumstances, relationships, physical health) realities. Compared with the control group, mothers in the intervention had significantly less symptoms of anxiety and depression at 6 months post-randomisation.

2019

STUDY DETAILS Fuhr DC, Weobong B, Lazarus A, Vanobberghen F, Weiss HA, Singla DR, … Patel V (2019). Delivering the Thinking Healthy Programme for perinatal depression through peers: an individually randomised controlled trial in India. The Lancet. Psychiatry, 6(2), 115–127

COUNTRY India

SUMMARY OF FINDINGS 280 women who were in their 2nd or 3rd trimester of pregnancy, who scored 10+ on the PHQ9 were randomized to either the peer-delivered 'Thinking Healthy Programme' plus enhanced usual care, or to enhanced usual care. The peers (local mothers known as Sakhis) delivered 6 -14 sessions that addressed issues relating to the health of the mother; the mother-infant relationship; and relationships with others. The programme led to a moderate effect on remission from depression by 6 months (indicated by PHQ9 score of less than 5).

TABLE 4.5. APPRAISAL OF QUALITY OF INCLUDED STUDIES USING CASP RCT APPRAISAL CHECKLIST (SEE TABLE 4.6 FOR CRITERIA).

CASP RCT APPRAISAL CHECKLIST CRITERIA (SEE TABLE 4..6 FOR DETAILS)											
STUDY	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**
Cooper et al, 2009	Y	Y	Y	P	Y	M	Y	Y	Y	P	Y
Morrell et al, 2009 (CBA)*	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y
Morrell et al, 2009 (PCA)*	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y
Roman et al, 2009	Y	Y	M	P	Y	M	Y	Y	Y	P	Y
Glavin et al, 2010	Y	N	M	N	P	Y	Y	Y	Y	P	Y
Milgrom et al, 2011a	Y	Y	Y	N	P	Y	Y	Y	Y	P	Y
Milgrom et al, 2011b	Y	Y	N	N	Y	Y	P	Y	P	P	Y
Ammerman et al, 2013	Y	Y	Y	P	Y	Y	Y	Y	Y	P	Y
O'Mahen et al, 2013a	Y	Y	Y	P	Y	Y	Y	Y	Y	P	Y
O'Mahen et al, 2014	Y	Y	Y	N	Y	Y	Y	Y	Y	P	Y
Nugent et al, 2014	Y	Y	Y	N	P	Y	Y	Y	Y	P	Y
Grote et al, 2015	Y	Y	Y	P	P	Y	Y	Y	Y	P	Y
Segre et al, 2015	Y	Y	Y	P	Y	Y	Y	Y	Y	P	Y
Goodman et al, 2015	Y	Y	Y	P	Y	Y	Y	Y	Y	P	Y
Zlotnick et al, 2015	Y	Y	Y	N	Y	Y	Y	Y	Y	P	Y
Sampson et al, 2016	Y	N	Y	NA	NA	NA	Y	Y	Y	P	Y
Glasser et al, 2016	Y	N	Y	NA	NA	NA	Y	Y	Y	P	Y
Holt et al, 2017	Y	Y	Y	P	Y	Y	Y	Y	Y	P	Y
Tandon et al, 2018	Y	Y	Y	P	Y	Y	Y	Y	Y	P	Y
Fuhr et al, 2019	Y	Y	Y	P	Y	Y	Y	Y	Y	Y	Y

*The Morrell et al (2009) study was a three-arm RCT comparing interventions provided by health visitors based on either a cognitive behavioural approach (CBA) or a person-centred approach (PCA).

TABLE 4.6. CASP RANDOMISED CONTROLLED TRIAL APPRAISAL CHECKLIST (CRITICAL APPRAISAL SKILLS PROGRAMME, 2018)

RATINGS FOR THE FOLLOWING CRITERIA LISTED IN TABLE 6 ARE:	
Y =	yes = criteria met
N =	no = criteria not met
M =	maybe = not clear whether criteria met
P =	partial = criteria partially met eg. for criteria 3, if the researchers, but not the participants were blind to the intervention
NA =	not applicable

1. Did the trial address a clearly focused issue?
2. Was the assignment of patients to treatments randomised?
3. Were all of the patients who entered the trial properly accounted for at its conclusion?
4. Were patients, health workers and study personnel 'blind' to treatment?
5. Were the groups similar at the start of the trial?
6. Aside from the experimental intervention, were the groups treated equally?
7. How large was the treatment effect? (amended to – is there evidence of treatment effect)
8. How precise was the estimate of the treatment effect? (amended to – is the treatment effect precise?)
9. Can the results be applied to the local population?
10. Were all clinically important outcomes considered?
11. Are the benefits worth the harms and costs?

4.4. Method for the use of the modified 'Distillation and Matching Model' to identify the core elements of effective interventions.

Rotheram-Borus et al (2012) describe the process of extracting core elements from multiple (often manualised, licensed and therefore expensive) evidence-based treatments into acceptable, accessible, alternative interventions as a 'disruptive innovation.' (p.463). The suggestion is that in order to reach more people in less time at lower cost it is necessary to simplify existing service provision by concentrating on the common and robust elements of interventions and exploring different modes of delivery that increase uptake **(ROTHERHAM-BORUS ET AL, 2012)**. A report produced by the Institute of Medicine (IOM) in America suggested that as many of the same symptoms occur in different diagnostic categories, or individuals experiencing psychological distress experience symptoms from more than one category, that a transdiagnostic approach to treatment is needed **(ENGLAND ET AL, 2015)**. This requires the identification of the elements that are common to psychological treatments **(ENGLAND ET AL, 2015)**.

The method for extracting core components used in this research is guided by the DMM **(CHORPITA ET AL, 2005)** and emulates the use of this method by Singla et al (2017) to identify the treatment components and implementation processes of effective interventions, for community based individuals with common MHPs, delivered by non-specialist providers in low and middle-income countries. The implication, manifest in the title of the article 'Psychological treatment for the world…' **(SINGLA ET AL, 2017)** is that it might be less resource intensive, and more cost-effective if a common elements approach was also incorporated into treatment strategies in high income countries.

Singla et al (2017) developed a taxonomy of treatment components that was composed of elements and techniques that 'cut across treatment packages.' An element is defined as 'a therapeutic activity or strategy' and a technique is defined as the 'skills that the therapist implements during a session to deliver an element' (p.154). Elements were further subdivided into specific elements (such as problem solving, behavioural activation, managing emotions, motivating social connections) and non-specific elements (such as empathy, collaboration and effective listening). Singla et al also explored commonly occurring implementation processes that might influence the way that the intervention is delivered and developed an implementation processes checklist to facilitate cross-study comparison (Table 4.6).

TABLE 4.7. KEY IMPLEMENTATION PROCESSES CHECKLIST (SINGLA ET AL, 2017)

WHERE?	**HOW ? TRAINING**
Rationale for setting	Who conducted the training?
Barriers and facilitators related to setting	How long was the training?
	What was the format of the training?
WHO?	What were the procedures for assessing competence?
Who delivered the treatment?	
How were they selected?	**HOW? SUPERVISION**
Rationale for selection	Who conducted supervision?
Demographics (age, gender, experience)	What was the format of the supervision?
Compensation	What supervision methods were used?
Certification process	
Is there access to an expert?	**HOW? TREATMENT CHARACTERISTICS**
What is the role of the expert?	How was the treatment delivered? (remote, group, individual)
WHAT?	How long was the treatment (intended vs actual)
Theoretical orientation	How many sessions? (intended vs actual, min and max, booster sessions)
Treatment class	How long were the sessions (intended vs actual, min and max)
Non-specific treatment components	Were sessions delivered in temporal sequence?
Specific treatment components	Was the treatment manualised?
In-session techniques	How was the quality of the therapy assessed?
Description of adaptations for specific context or target groups	What is the no. or percentage of individuals who completed the entire treatment package?

A modified version of the DMM was used in this analysis, owing to the constraints of time and resources. The method involved interrogating the 20 articles identified in the rapid review to extract the common elements and techniques used in the intervention. If insufficient detail was included in the article, requests were made to the main author for more detail (a copy of the manual if there was one) about the specific elements of the intervention. The elements were categorised according to the taxonomy and key implementation processes checklist developed by Singla et al (2017). As the purpose of the Singla et al study was comparable to the objective of this study, a comparison was made between the commonly occurring elements in the Singla et al study and those identified in this study.

4.5. Results of the modified DMM process

The most frequently endorsed specific elements synthesized from the 20 studies included in the modified distillation and matching process were: talking about feelings/mood management; psychoeducation; problem-solving; goal-setting; managing relationships; activating support networks; and maternal and infant well-being/care (Table 4.7). The findings from this study are compared with the findinngs in the Singla et al (2017) study in table 4.8.

TABLE 4.7. CORE COMPONENTS (SPECIFIC ELEMENTS) OF EFFECTIVE INTERVENTIONS EXTRACTED FROM THE ARTICLES IDENTIFIED IN THE SYSTEMATIC REVIEW (PART 1 OF 3)

*** = manual available**

	Cooper et al, 2009*	PONDeR (Morell et al 2009)* CBA	PONDeR (Morell et al 2009)* PCA	Roman et al, 2009	Glavin et al. 2010	Towards Parenthood (Milgrom et al 2011a)*	Adjunctive counselling Milgrom et al, 2011b	Frequency
Behavioural Activation		✔				✔	✔	3
Activating support networks	✔			✔		✔	✔	4
Rethinking childhood experiences						✔		1
Cognitive techniques		✔				✔	✔	3
Motivational interviewing/persistent outreach				✔		✔		2
Foster assertive communication skills				✔		✔		2
Coping skills/identify past ways of coping				✔		✔		2
Enhancing self-esteem				✔		✔		2
Goal setting	✔	✔		✔		✔	✔	5
Managing expectations			✔	✔		✔		3
Managing relationships	✔	✔		✔		✔	✔	5
Managing transitions			✔	✔		✔		3
Maternal and infant Well-being/self-care	✔	✔		✔		✔		4
NDC techniques/therapeutic listening			✔	✔	✔		✔	4
Nurturing parent-infant relationships	✔			✔		✔		3
Nutrition				✔		✔		2
Parenting skills	✔	✔		✔		✔		4
Psychoeducation	✔	✔	✔	✔	✔	✔	✔	7
Problem solving		✔	✔	✔	✔	✔	✔	6
Physical activity/exercise				✔		✔		2
Relaxation techniques						✔	✔	2
Stress management				✔		✔		2
Talking about feelings/mood management	✔	✔	✔	✔	✔	✔	✔	7

TABLE 4.7. CORE COMPONENTS (SPECIFIC ELEMENTS) OF EFFECTIVE INTERVENTIONS EXTRACTED FROM THE ARTICLES IDENTIFIED IN THE SYSTEMATIC REVIEW (PART 2 OF 3)

*** = manual available**

	IH - CBT Ammer-man et al, 2013	O'Mahen et al (2013a)	Helping with Depression O'Mahen et al 2014)	(Nugent et al, 2014)	Collaborative Care (Grote et al 2015)	Listening Visits (Segre et al, 2015)	Perinatal Dyadic Psychotherapy (Goodman et al, 2015)*	Cumulative frequency
Behavioural Activation/activity scheduling	✔	✔	✔			✔		3 + 5
Activating support networks		✔	✔		✔		✔	4 + 4
Rethinking childhood experiences							✔	1 + 1
Cognitive techniques	✔	✔	✔				✔	3 + 4
Motivational interviewing/persistent outreach	✔	✔			✔		✔	2 + 4
Developing communication skills	✔		✔				✔	2 + 3
Coping skills	✔	✔	✔		✔		✔	2 + 5
Enhancing self-esteem	✔						✔	2 + 2
Goal setting	✔	✔	✔				✔	5 + 4
Managing expectations		✔		✔			✔	3 + 3
Managing relationships	✔	✔	✔		✔		✔	5 + 5
Managing transitions	✔		✔		✔		✔	3 + 4
Maternal and infant Well-being/self-care	✔		✔	✔			✔	4 + 4
NDC techniques/therapeutic listening						✔	✔	4 + 2
Nurturing parent-infant relationships	✔		✔	✔			✔	3 + 4
Nutrition								2 + 0
Parenting skills/practical support	✔		✔	✔			✔	4 + 4
Psychoeducation		✔	✔		✔	✔	✔	7 + 5
Problem solving	✔	✔	✔		✔	✔	✔	6 + 6
Physical activity/exercise								2 + 0
Relaxation techniques								2 + 0
Stress management	✔	✔					✔	2 + 3
Talking about feelings/mood management	✔	✔	✔		✔	✔	✔	7 + 6

TABLE 4.7. CORE COMPONENTS (SPECIFIC ELEMENTS) OF EFFECTIVE INTERVENTIONS EXTRACTED FROM THE ARTICLES IDENTIFIED IN THE SYSTEMATIC REVIEW (PART 3 OF 3)

*** = manual available**

	ROSE (Zlotnik et al 2015)	Problem solving therapy (Sampson et al, 2016)	Supportive counselling (Glasser et al, 2016)	PRIMER (Holt et al, 2017)	Mothers and Babies Course (Tandon et al 2018)*	Thinking Healthy (Fuhr et al, 2019)*	Cumulative frequency (% of studies)
Behavioural Activation		✔			✔	✔	3 + 5 + 3 = 11 (55)
Activating support networks	✔		✔	✔	✔	✔	4 + 4 + 5 = 13 (65)
Rethinking childhood experiences					✔		1 + 1 + 1 = 3 (15)
Cognitive techniques					✔	✔	3 + 4 + 2 = 9 (45)
Motivational interviewing/persistent outreach		✔		✔			2 + 4+ 2 = 8 (40)
Fostering assertive communication skills					✔		2 + 3 + 1 = 6 (30)
Coping skills/identify past ways of coping		✔		✔		✔	2 + 5 + 3 = 9 (45)
Enhancing self-esteem							2 + 2 + 0 = 3 (15)
Goal setting	✔	✔		✔	✔	✔	5 + 4 + 5 = 14 (70)
Managing expectations		✔		✔		✔	3 + 3 + 3 = 9 (45)
Managing relationships	✔				✔	✔	5 + 5 + 3 = 13 (65)
Managing transitions	✔				✔	✔	3 + 4 + 3 = 10 (50)
Maternal and infant Well-being/self-care					✔	✔	4 + 4 + 2 = 10 (50)
NDC techniques/therapeutic listening			✔			✔	4 + 2 + 2 = 8 (40)
Nurturing parent-infant relationships					✔	✔	3 + 4 + 2 = 9 (45)
Nutrition						✔	2 + 0 + 1 = 3 (15)
Parenting skills/practical support					✔		4 + 4 + 1 = 9 (45)
Psychoeducation				✔	✔	✔	7 + 5 + 3 = 15 (75)
Problem solving					✔	✔	6 + 6 + 2 = 14 (70)
Physical activity/exercise						✔	2 + 0 + 1 = 3 (15)
Relaxation techniques					✔	✔	2 + 0 + 2 = 4 (20)
Stress management					✔	✔	2 + 3 + 2 = 7 (35)
Talking about feelings/mood management	✔	✔	✔	✔	✔	✔	7 + 6 + 6 = 19 (95)

TABLE 4.8. COMPARISON OF FREQUENCY OF ELEMENTS IN THE 20 EFFECTIVENESS STUDIES IDENTIFIED IN THIS RAPID REVIEW AND THE FREQUENCY OF ELEMENTS IN THE 27 EFFECTIVENESS STUDIES IDENTIFIED IN THE SYSTEMATIC REVIEW CONDUCTED BY SINGLA ET AL (2017)

FOCUS OF THE REVIEW	THIS STUDY (BASED ON 20 STUDIES) Interventions delivered by non mental health-specialists to mothers with MHPs.	SINGLA ET AL (2017) (BASED ON 27 STUDIES) Interventions delivered by non-specialist providers for the treatment of common MHPs in low and middle income countries (almost half the studies included in this review involved parents, mainly mothers)
	% frequency of endorsement of elements across all studies (alternative descriptors in Singla et al (2017) study)	
ELEMENTS		
Talking about feelings/ mood management	95%	74% (identifying/eliciting affect)
Psychoeducation	75%	85%
Problem solving	70%	78%
Goal setting	70%	52%
Managing relationships	65%	30%
Activating support networks	65%	85%
Behavioural activation	55%	56%
Managing transitions	50%	44% (self-monitoring)
Maternal and infant well-being/ self-care	50%	Not specifically mentioned
Coping skills	45%	Not specifically mentioned
Managing expectations	45%	Not specifically mentioned
Nurturing parent-infant relationships	45%	Not specifically mentioned
Cognitive techniques	45%	63%
Parenting skills/practical support	42%	Not specifically mentioned
NDC techniques/therapeutic listening	40%	78%
Motivational interviewing/ persistent outreach	37%	19%
Stress management	35%	Not specifically mentioned
Fostering assertive communication skills	30%	59%
Relaxation techniques	20%	22%
Re-thinking childhood experiences	15%	Not specifically mentioned
Enhancing self-esteem	15%	22% (self-talk, self- praise)
Nutrition	15%	Not specifically mentioned
Physical activity/exercise	15%	Not specifically mentioned

The checklist advocated by Singla et al (2017) was used to tabulate key implementation processes described in the 20 studies (see Table 1, Appendix 1). The findings can be summarised as follows:

- Interventions were delivered by health visitors/public health nurses/maternal and child health nurses/ nurses in 9 of the studies; social workers/home visitors delivered the interventions in 6 of the studies; lay/community health workers in 3 of the studies; mothers in 1 of the studies and psychologists/mental health workers in 2 of the studies. The number equates to more than 20 because more than 1 practitioner was involved in delivery in 1 of the studies **(ROMAN ET AL, 2009)**.
- The majority of the interventions were delivered in the home (18/20) to mothers on a 1-on-1 basis, although it was often stated that the location of delivery could be adapted to maternal preference.
- In 13 of the studies, details about the trainer, the format of the training or the effectiveness of the training (in terms of practitioner competence) were not clearly specified.
- In 15 studies insufficient detail was provided about the supervisor, the format or methods of supervision. The number of designated sessions for the described interventions varied from 4 to a maximum of 50. The length of the sessions ranged from 15 – 60 minutes.
- Sixteen of the 20 studies were based on manualised interventions.
- For the 11 studies providing completion rates, these ranged from 33 – 100%.
- As in the Singla et al (2017) study, findings from this study indicate a lack of information about training (including assessment of competence) and variable levels of information about the methods, frequency and format of supervision.

4.6 Discussion

Philosophical hermeneutics requires us to be open to the possibilities of seeing something which is not there, as being there ('aletheia'). Hermeneutics is not about generalising but about paying attention to the particular. It is about connecting with elements that draw you in and stimulate creative thinking **(MOULES, 2002)**. We can never make progress if the expectation is that we are all going to do exactly the same thing and reach exactly the same conclusions. 'In a hermeneutic study, it is the philosophical insights, and the thoughts stumbled across, that can most powerfully call one into thinking and thus shape the analysis and findings of the research' **(SMYTHE & SPENCE, 2012 P.21)**.

The outcome of reviewing the systematic reviews and primary studies included in the rapid review

The elements of the texts of the 40 systematic reviews and the 20 primary studies that I have found meaningful and that I need to think more about, in relation to the future of LVs, are summarised in the following bullet points:

- Not all interventions are more effective than the usual care comparator indicating the need for clearer description of what is meant by usual care, a better understanding of the mechanisms of action of the intervention, and the mediators and moderators that influence effectiveness **(GOODMAN ET AL, 2015; LEIS ET AL, 2009)**.
- Effect sizes are often small when comparing mothers who receive any intervention to mothers who receive usual care because those mothers who receive usual care often benefit from the genuine interest of a compassionate, trusted, non-judgemental healthcare provider/lay worker/peer supporter/researcher **(GOODMAN ET AL, 2015; MORRELL ET AL, 2009)**;
- Identifying and treating mothers with sub-threshold symptoms, or preventing symptoms from occurring, may appear to be less effective than interventions targeting mothers meeting diagnostic criteria for a MHP because there will inevitably be a smaller difference in outcome between symptom prevention

or reduction compared with recovery from a diagnosable illness **(MORRELL ET AL, 2016; WERNER ET AL, 2015)**;

- Although CBT/IPT appear to be the interventions most frequently cited as effective, the equivalent effectiveness of different interventions implies that it may not be the techniques used that are the most important factor **(LAVENDER ET AL, 2016; STEPHENS ET AL, 2016)**;
- High attrition rates imply that the intervention under study might not be acceptable to everyone **(SOCKOL ET AL, 2011; MAHDI ET AL, 2018; O'MAHEN ET AL, 2013B; VAN RAVESTEYN ET AL, 2017)**.
- The complex circumstances of mothers in the perinatal period present multiple potential modifiable factors that could be the target of both preventive and therapeutic interventions **(ALDERDICE ET AL, 2013; DENNIS, 2014; FONTEIN-KUIPERS ET AL, 2014; JOHANSEN ET AL, 2019; ROMAN ET AL, 2009; SOCKOL ET AL, 2013)**;
- Interventions with a clear programme structure, starting in pregnancy, extending across the postnatal period, integrated into routine maternal care, adapted to the needs and preferences of mothers, and including other members of the family are more likely to be acceptable and effective **(ALDERDICE ET AL, 2013; CHOWDHARY ET AL, 2014; CLUXTON-KELLER & BRUCE, 2018; MAHDI ET AL, 2018; MUNODAWAFA ET AL, 2018)**;
- Interventions need to incorporate assessments and interventions that address maternal and paternal mental health, the couple relationship, support networks, parent-infant interaction and parenting capacity **(AMMERMAN ET AL, 2013; CUIJPERS ET AL, 2015; NUGENT ET AL, 2014; SOCKOL, 2018; TSIVOS ET AL, 2015; WERNER ET AL, 2015)**;
- Interventions designed to generate understanding about the needs and capabilities of mothers and infants may be more acceptable to mothers and family members and may be effective in the prevention of postnatal depression **(FUHR ET AL, 2019; NUGENT ET AL, 2014)**.
- Interventions incorporating assessment and intervention are most likely to be cost-effective **(CAMACHO & SHIELDS, 2018)**.
- Some interventions (such as mind-body interventions) show promise in reducing symptomatology but are not yet supported by a sufficient number of trials with robust methodology **(ALDERDICE ET AL, 2013; SMITH ET AL, 2018)**;
- Simple strategies may be effective **(DIXON & DANTOS, 2017)**;
- Interventions incorporating collaborative care are beneficial for mothers with multiple and complex needs **(GROTE ET AL, 2015)**;
- Multimodal interventions may include guided self-help, group work, peer or telephone support **(FIRTH ET AL, 2016; FONSECA ET AL, 2018; JOHANSEN ET AL, 2019; LIN ET AL, 2018)**;
- There may be synergistic benefits to be gained from multi-component interventions **(CHOWDHARY ET AL, 2014; DENNIS & DOWSWELL, 2013A; EVANS ET AL, 2018; GOODMAN & GARBER, 2017; NILNI ET AL, 2017; SOCKOL ET AL, 2013)**.
- Partial assessment of cost-effectiveness, as the result of variable time horizons and/or the exclusion of relevant outcomes from the analysis. may contribute to misleading, non-generalisable recommendations **(GURUNG ET AL, 2018)**.
- Pre-post-, and intra-intervention support may be needed to enhance engagement and prolong the beneficial impacts of the intervention **(GOODMAN & GARBER, 2017; MINIATI ET AL, 2014; O'MAHEN ET AL, 2013A)**.
- Non-mental health specialists delivering interventions must be carefully selected and appropriately trained **(AMMERMAN ET AL, 2010; DIXON & DANTOS, 2017; MUNODAWAFA ET AL, 2018**);

- There is evidence to suggest that public health nurses, as non-mental health specialists, can deliver effective perinatal mental health interventions **(HOLT ET AL, 2017; MILGROM ET AL, 2011B).**
- Dedicated time and expertise from secondary or tertiary mental health professionals is needed to provide consultation, supervision and collaborative care if the intervention is delivered by non-mental health specialists **(AMMERMAN ET AL, 2010; BARLOW ET AL, 2010).**

The outcome of the distillation and matching model process

The final list of commonly occurring elements that emerged from using the DMM made sense to me and many of the elements seem very relevant to the role of the HV in supporting mothers with MHPs. The findings imply that an amalgamation of strategies from different treatment modalities might be helpful.

Psychoeducation is one of the most frequently occurring components in all the studies included in both this analysis and that undertaken by Singla et al (2017). Psychoeducation includes therapeutic and educational techniques with the purpose of providing information about what to expect and how to cope within the context of a therapeutic relationship that offers structure, safety, feedback, and time to process, thoughts, feelings, ideas and options for recovery **(LUKENS & MCFARLANE, 2004).**

Mothers with low social support are more likely to experience perinatal MHPs **(BIAGGI ET AL, 2016; NORHAYATI ET AL, 2015).** Activating social networks and developing assertive communication skills to manage intimate partner relationships are key features of the majority of the programmes included in this analysis **(COOPER ET AL, 2009; FUHR ET AL, 2019; GLASSER ET AL, 2016; GOODMAN ET AL, 2015; GROTE ET AL, 2015; HOLT ET AL, 2017MILGROM ET AL, 2011A, 2011B; O'MAHEN ET AL, 2013A; O'MAHEN ET AL, 2014; ROMAN ET AL, 2009; TANDON ET AL, 2018; ZLOTNICK ET AL, 2015).**

A longitudinal study involving 494 Japanese mothers indicated that both the number of people available to provide support and the perceived quality of that support antenatally is inversely related to maternal self-assessment of mother-infant bonding and depressive symptoms during pregnancy and 1 month postpartum **(O'HARA ET AL, 2017).** A cross-sectional survey of antenatal mothers recruited at 14 – 16 weeks gestation found a significant association between perceived social support and mental well-being **(GINJA ET AL, 2018).** In a longitudinal follow-up of 54 women recruited during pregnancy to participate in a RCT, the two aspects of social support that conferred the greatest protective effect were 'reassurance of worth' (acknowledging skills and abilities) and 'reliable alliance' (having access to someone who can be relied on in all circumstances) **(MILGROM ET AL, 2019. P.11).**

Supporting mothers to negotiate the shared responsibilities of parenthood, nurture relationships with significant others and access sources of support is effective in preventing and ameliorating the impact of MHPs **(CLUXTON-KELLER AND BRUCE, 2018; FISHER ET AL, 2010; MILGROM ET AL, 2011A; PILKINGTON ET AL, 2015; ROMAN ET AL, 2009; WYNTER ET AL, 2013).** Promoting supportive partner relationships is also likely to have a beneficial impact on infant outcomes **(STAPLETON ET AL, 2012).** There are therefore many reasons why HVs should include consideration of the quality of intimate partner relationships and the availability of support in perinatal mental health interventions.

The WHO 'Thinking Healthy' programme, developed to be delivered by non-mental health specialists to mothers who might be at risk of developing postnatal depression, has three main areas of focus: the personal health of the mother; her relationship with the baby; and her relationship with others **(FUHR ET AL, 2019).** In the 'Coping with Depression' self-help guide used by Canadian mothers, and health

professionals supporting them, the NEST-S acronym is used to remind mothers of the importance of nutrition, exercise, sleep and rest, time for self and support. **(BC REPRODUCTIVE MENTAL HEALTH PROGRAM AND PERINATAL SERVICES BC, 2011)**. Infants depend on mothers for their well-being and survival. Promoting maternal self-care is therefore an essential aspect of perinatal mental health interventions.

The reciprocal interaction between parenting stress and maternal MHPs highlighted in the systematic review by Werner et al (2015) calls for equal attention to be given to the factors that influence Maternal Parental Self-efficacy (MPSE), maternal caregiving, maternal attributions and representations of themselves, their infant and the mother-infant relationship, as well as the causes and symptoms of MHPs. Several of the interventions identified in the rapid review included strategies to help mothers recognize and respond to the unique strengths and capabilities of their infant **(AMMERMAN ET AL, 2013; COOPER ET AL, 2009; FUHR ET AL, 2019; GOODMAN ET AL, 2015; MILGROM ET AL, 2011A; NUGENT ET AL, 2014; O'MAHEN ET AL, 2014; TANDON ET AL, 2018)**.

Equally the process of reviewing key implementation processes revealed what previous reviews of the literature have indicated with respect to inadequate information, or emphasis, on the quality and effectiveness of training or the availability, format or method of supervision. Criticism is sometimes levied at campaigns to increase detection and management of health issues that only deploy a 'train and hope' strategy **(STOKES & BAER, 1977)**. The assumption is that training on its own is sufficient to change practice, whereas in reality practitioners may be reluctant or unable to deliver the intervention and may not deliver the intervention as the trainers intended **(NOONAN ET AL, 2017)**. Supervision should include 'coaching', reflective and restorative elements **(WALLBANK, 2012)**.

The number of sessions in the 20 studies included in the distillation and matching process varied from 4 – 50. Although the range is broad, the majority of intervention protocols specify the number of sessions that should be offered. A retrospective review of the records of 1850 individuals receiving a low intensity intervention for anxiety or depression from IAPT services indicated that there is a dose-response relationship between number of sessions and symptom reduction **(DELGADILLO ET AL, 2014)**. According to this study, at least 4 therapy sessions are required to confer clinically significant improvement with only marginal additional improvement seen after six sessions. High rates of 'drop-out' in sessions 1-3 indicate the need to find ways to maximize engagement and retention.

The number of sessions recommended in LV interventions varies from 4 – 8. In the PoNDER RCT **(MORRELL ET AL, 2009)**, the protocol specified that 8 sessions should be offered by the HV to mothers with postnatal depression (mean number of sessions actually delivered = 4.1). In the American version of LVs the RCT protocol specified that 6 sessions should be offered (mean = 4.78) **(SEGRE ET AL, 2015)**. The Norwegian equivalent of LVs involved an initial exploratory session offered to mothers with EPDS score of 10+ with a further 2- 7 sessions offered if needed (mean = 3.4) **(GLAVIN ET AL, 2010)**. In a 6 week counseling intervention based on cognitive behavioural techniques offered by Australian child and family health nurses (equivalent to HVs) to mothers with PND, as an adjunct to GP management of postnatal depression, the average number of nurse-delivered weekly sessions attended by the mothers was 4.6 **(MILGROM ET AL, 2011B)**. In an American study of in-home CBT to depressed mothers 15 sessions plus 1 booster session were recommended **(AMMERMAN ET AL, 2013)** based on the premise that sufficient time in treatment is required to enable mastery of new skills and booster sessions are needed to promote recovery, sustain remission and prevent relapse (mean = 11.2). Based on the available evidence of maximum benefit it would appear logical for HVs to offer 6 sessions to mothers with MHPs, in anticipation of sustained

engagement for at least 4 sessions whilst also recognizing that more may be needed for mothers coping with particularly challenging circumstances.

It may be relevant for HVs to consider providing a blended intervention that incorporates individual 1-on-1 sessions backed up by telephone contact **(BROOM ET AL., 2015; DROZD ET AL., 2018; SHOREY ET AL., 2015)** and/or smartphone or internet-based assessments, activities and peer support **(DOHERTY ET AL., 2018; LEE ET AL., 2016; MILGROM ET AL., 2016; O'MAHEN ET AL., 2014; SHOREY ET AL., 2017)**.

4.7. Strengths and limitations

As a result of the very detailed and time consuming process of identifying the commonly occurring elements and key implementation processes of effective interventions identified in the rapid review, I am struck by several aspects of both the method and the results. To start with, although I understand the requirement for a thorough, transparent and reproducible process for identifying relevant literature, I was surprised by some of the studies that merited inclusion and disappointed that others, that I found interesting, were excluded. Even though I might endeavour to be objective, the likelihood is that these will inevitably inform my future thinking because I have connected with their content.

There is evidence from RCT's to suggest that interventions delivered by public health nurses may be equally or more effective than the same interventions delivered by mental health specialists **(COOPER ET AL., 2003; HOLT ET AL., 2017; MILGROM ET AL., 2011B)**. It may therefore be useful to see if there are other interventions delivered by mental health specialists that could be delivered by nurses.

Some of the studies indicated minimal, though still clinically or statistically significant outcomes, between the intervention and control groups. Rather than dismissing the intervention as of limited value, it might be useful to reflect on why this might be so. For example, in the early phases of development and testing of a new intervention, the providers of the intervention may not have had the benefit of repeated practice and experience of delivering the intervention and may still be in the process of developing their understanding and honing their skills.

Another reason for the lack of relative effectiveness of the intervention may be due to equally beneficial outcomes recorded for both groups that may be a by-product of the minimal difference between the intervention and control **(GOODMAN ET AL., 2015)**, or the process of assessment acting as the intervention **(DARWIN ET AL., 2013)**. Another reason might be that the assessment tools used to measure outcomes may not be culturally appropriate for the target population **(GLASSER ET AL., 2016)**. In an RCT testing the CARE (Communicating and Relating Effectively) intervention developed by Horowitz et al (2013) to promote sensitive, reciprocal mother-infant interactions in mothers with postnatal depression, significant improvements in depressive symptoms and mother-infant interaction were noted from baseline at 6 weeks to 9 months postpartum for all 134 mothers recruited to the study. The authors of this study concluded that 'focused attention and support from a trained clinician, i.e. a nurse, may be appropriate as a first-line treatment for PPD and maternal-infant interaction difficulties.' **(HOROWITZ ET AL., 2013 P.297)**.

The extraction of commonly occurring components and implementation processes depends on the popularity of the psychological or psychosocial approach that guides the intervention. As the majority of perinatal mental health interventions are based on CBT **(NILLNI ET AL., 2018; STEPHENS ET AL., 2016; VAN RAVESTEYN ET AL., 2017; WERNER ET AL., 2015)** it is possible that components normally included in CBT will dominate the range of elements identified and therefore these will be prioritised in the development

of transdiagnostic treatments. Interventions informed by the principles of non-directive counselling (NDC) inevitably include less elements, or the non-specific elements considered essential for NDC are presumed, and therefore not included in the descriptions of interventions, so may not feature in the list of commonly occurring elements.

Compared to research articles, manuals usually provide more detail, so a greater number of elements will be described in interventions where manuals are available. Elements that are not frequently included risk exclusion from a lexicon of effective elements even though they may have the potential to produce beneficial outcomes. It may not be possible to differentiate the overall intervention into individual components. The most commonly occurring components may not be the components that confer benefit. It may be the synergistic effect of a combination of components that is required to achieve the desired result. Use of a specific template to categorise common elements or key implementation processes risks failing to take into account non-specified processes that might be important.

The majority of systematic reviews and single trials focus on PPD. This means that interventions targeting other MHPs or other ways of expressing maternal stress or distress are under-represented **(VAN RAVESTEYN ET AL, 2017)**. Although the purpose of exploring transdiagnostic approaches is to develop a composite intervention to respond to symptoms rather than diagnoses, the selection of studies is based on those exploring the effectiveness of interventions for mothers who meet the criteria for a diagnosable illness. This means that vulnerability factors that might predispose mothers to mental ill-health are not taken into account. The WHO report on effective interventions to prevent mental disorders refers to the strong evidence suggesting that it is the 'cumulative effect of the presence of multiple risk factors, the lack of protective factors and the interplay of risk and protective situations that predisposes individuals to move from a mentally healthy condition to increased vulnerability, then to a mental problem and finally to a full-blown disorder' **(SAXENA ET AL, 2006 P.6)**. Risk factors for mental illness may also contribute to poor physical health, compromised relationships and social exclusion.

Equally, limited information is available on the mental health benefits of lifestyle or positive psychology interventions even though there is evidence to suggest that these interventions are effective in reducing anxiety and depression and promoting positive mental health **(CHAKHSSI ET AL 2018; HENDRIK ET AL, 2019)**. Promoting mental well-being is the top priority of the European public mental health agenda **(FORSMAN ET AL, 2015)**.

4.8. Conclusions

The study by Singla et al (2017) has shown that transdiagnostic approaches, involving a 'set of common practice elements', can be delivered in varying combinations, by non-specialist practitioners to address a range of problems **(SINGLA ET AL, 2017 P.151)**. Given the transdiagnostic symptoms that mothers often experience in the perinatal period it makes sense to develop an intervention based on the common elements/ active ingredients apparent in multiple therapeutic modalities **(ENGLAND ET AL, 2015)**. Whilst acknowledging the limitations of the rapid review and the modified distillation and matching process, the identification of common elements provides a useful foundation for reflecting on the implications of this analysis for health visiting perinatal mental health practice. It is likely that all the elements could be included in an enhanced version of LVs although the existence of a **'LIST' MAY** inhibit exploration of other possibilities. Should all the elements on the list be included or only those that were present in the majority of the studies? On another day, at another time, using different search criteria, or even the same criteria, the list might not look the same.

This methodologically rigourous two-part process highlights the enriching influence of a hermeneutical perspective. It is the thinking that has been stimulated around and above the systematic approach that has enhanced my understanding and made me think about what is not included, as much as what is included, in the review of the evidence and the search for common elements. This also resonates with what Gadamer says about engagement with text in that the text that we seek to understand will raise as many questions as answers.

That has led me to re-read texts or explore new ones to better understand the challenges of interpretation and the impermanence of knowledge. What is it that I need to know, and more importantly, what is it that I need to share? Gadamer encourages the pursuit of understanding through dialogical connections with words that inspire, whether that is through people, text or art. Gadamer encourages the enrichment of the process of understanding through connection with all forms of expression, not necessarily just academic literature. Immersion in this particular stage of the research has made me think of Heisenberg's uncertainty principle in relation to the certainty of uncertainty, and T S Eliot's 'Choruses from the Rock' - Where is the Life we have lost in living? Where is the wisdom we have lost in knowledge? Where is the knowledge we have lost in information?

4.9. Chapter summary

The purpose of this chapter was to describe a systematic rigourous process for exploring possible elements that could be included in an updated LV. As a result of using a combination method of a rapid review and Chorpita et al's (2005) DMM, a list of commonly occurring elements in interventions delivered by non-mental health specialists to community based mothers with perinatal MHPs has been created. The processes that might enhance or compromise implementation have been identified. The exercise has provided a useful spring-board for thinking about what elements could be included in a future iteration of LVs. This is only a beginning and not an end. There is much more to learn and to understand. However, this exercise has revealed useful information and will be integrated in some way in a proposal for an up-dated, evidence-informed, manualised intervention to guide the support that HVs provide to mothers with MHPs.

Chapter 5
Identifying or Developing the Theory

5.1. Introduction

The MRC guidance for developing and evaluating complex interventions **(CRAIG ET AL, 2008)** and the MRC guidance on process evaluations **(MOORE ET AL, 2014)** emphasise the need for a comprehensive understanding of why a problem occurs (the predisposing and precipitating factors), the interventions that might be appropriate, and how the interventions are supposed to work in the real world of clinical practice. This includes the use of formal and informal theories to explain how interactions between causes, symptoms, intervention components, providers, recipients and context culminate in both expected and unexpected outcomes **(MOORE & EVANS, 2017)**.

Theories can be used to explain the individual elements of an intervention or how the elements interact to achieve the intended outcomes (logic model, programme theory, theory of change). As this stage of the research is exploratory rather than definitive, it is not appropriate to develop a logic model or programme theory because a conclusion has not been reached about the elements that will be included in the intervention. A review of the literature is the method used to identify the theories that provide the logic for the elements that are, or could be, included in a HV perinatal mental health intervention. The starting point for this investigation has to be a clear definition of 'theory'.

Davidoff et al (2015 p.229) state that 'The urge to find and use reasons – and thus to theorise – is irresistible; people look for explanations, understandings and causes easily and almost automatically, virtually every minute of the day'. A more formal definition of a theory can be found in Booth & Carroll's article describing a systematic approach to the identification of theories to inform or explain mechanisms of action in complex interventions **(BOOTH & CARROLL, 2015 P.221)**. 'A theory is 'a set of inter-related concepts, definitions and propositions that present a systematic view of events or situations by specifying relations among variables, to explain and predict the events or situations'.

There is some debate about whether theoretically informed interventions are more effective than those that are not **(DAVIS ET AL, 2014)**. The reasons given for this variability include selection of inappropriate theories, poorly applied theories, or a preferential focus on formal rather than informal theories. Every clinician in every clinical encounter combines prior experience with foundational knowledge (theory) to provide responsive care (phronesis). Whether it is formal or informal theories that underpin clinical judgement, there is inevitably a theoretical foundation for the decisions made and actions taken. Tsoukas (2017) argues that owing to the complexity of systems, relationships and interventions that it is likely that many theories might be appropriate to inform or explain the casual pathway or mechanisms of action of interventions. The challenge lies in identifying and articulating the formal theories that might be relevant.

Theories are not always explicitly described in research articles. Campbell et al (2014), in their search for theories linking income and health, found that only 24% of the 272 papers included in their review were identified through searches of electronic databases, mostly because the relevant search terms were not included in the title or abstract. Ayers and Olander (2013) found that only 15% of 5,607 research papers on postnatal depression included the word 'theory' and suggested that the absence of reference to theories in perinatal research arose from difficulties in deciding when to use a theory, not knowing which theory to use or not being able to operationalize the theory in research. The purpose of this chapter is to attempt to articulate the theories that might help to guide the development of a re-designed health visitor-led perinatal mental health intervention.

5.2. Method

Booth and Carroll (2015) have developed the mnemonic BeHEMoTH (Behaviour of Interest; Health context; Exclusions; Models or Theories) to describe the components of a systematic search strategy for identifying theories (Table 5.1). The BeHEMoTH critera were used in combination with the search terms used in the search strategy for effective interventions (Table 4.2), with the exception of the health visitor/nurse section. Articles were tagged and stored using Mendeley reference management software. Key concepts and theories were identified from analytical reading of these articles, supplemented with additional concepts and theories identified as a result of forward and backward citation tracking, previous literature reviews, and those described in empirical studies of perinatal mental health interventions **(AYERS AND OLANDER, 2013; BONNELL ET AL, 2013)**. As several literature reviews have been completed during this PhD study, any articles that were identified and read for another purpose, that included reference to relevant theories, were also added to the cache of articles identified using the systematic search strategy.

As reference to theories in literature may be sparse, or difficult to find **(AYERS & OLANDER, 2013; CAMPBELL ET AL, 2014**), the search strategy had to balance the risks of undermining transparency, introducing subjective bias, and omitting theories worthy of consideration, with pragmatic considerations of time and relevance. Theories were selected if they provided insight into the modifiable determinants of maternal mental ill-health that relate to any part of the causal pathway and the role of the HV. Selection of relevant theories was guided by hermeneutic principles in the sense that they were included if they enhanced understanding and added 'meaning' to the review **(GREENHALGH ET AL, 2017)**.

TABLE 5.1. BEHEMOTH CRITERIA FOR A SEARCH STRATEGY OF THEORIES RELATED TO THE PREVENTION, IDENTIFICATION AND MANAGEMENT OF PERINATAL MENTAL HEALTH PROBLEMS

Behaviour of Interest	Interventions directed at the prevention, identification and management of perinatal mental health problems
Health context	Community or primary care
Exclusions	Statistical models
Models or Theories	Models, theories, frameworks, or concepts

5.3. Results

A search of the CINAHL database using the specified search terms resulted in 2,328 articles. After a detailed examination of the title and abstract and restriction of the timeframe to the last ten years (2009 – 2019), the list of relevant articles was reduced to 307. 140 theories were identified (Table 5.2).
The results of this literature search indicate that there are a plethora of theories, derived from a range of disciplines and targeting multiple aspects of intervention delivery, that could be used to inform perinatal mental health research and practice, **(AYERS & OLANDER, 2013)**. The theories were categorised according to the factors that might influence or explain the causes, symptoms, consequences and protective factors relating to maternal mental ill-health. Theories that explain the mechanism of action of interventions, and the characteristics and behaviour of mothers and health professionals were also identified in order to reveal what works, why, and under what circumstances. All interventions take place within a wider, complex, adaptive system of care. If the system fails to pro-actively support the intervention, even the most promising innovations can become marginalised **(GHATE, 2015)**. There is now a much greater emphasis on the parameters, and impact, of contextual factors on the generalisability and sustainability of interventions. As there are so many theories, models and frameworks included under the general banner of Implementation Science only a limited number of these are included in the list in table 5.2.

TABLE 5.2. THEORIES THAT HELP TO EXPLAIN WHY INTERVENTIONS DO OR DO NOT WORK AND WHAT HVS COULD DO DIFFERENTLY TO IMPROVE THE SUPPORT THEY PROVIDE TO MOTHERS WITH MHPS.

THEORY
Causes/explanations (n=21)
Adverse Childhood Experiences
Allostatic load theory
Biological embedding of childhood adversity
The dynamic Biopsychosocial model of health
Circadian rhythm disruption
Development Origins of Health and Disease
Diasthesis-stress model
Generalised Unsafety Theory of Stress
Interoception
Mismatch Hypothesis of Depression
The Cytokine Theory of Depression
The Dynamic Human Microbe Cycle
The Evolutionary Theory of Loneliness
The Gut Microbiome and Mental Health
The inflammatory Hypothesis of Depression
The Microbiota-Inflammasone Hypothesis of major Depression
Theory of Basic Emotions
Theory of Constructed emotion
Theory of Mentalised Affectivity
Trauma
Tripartite Model of Affect Regulation
SYMPTOMS (N=8)
Pathogen – Host Defence Theory of Depression (PATHOS-D)
Sleep disturbance
The Circumplex Model of Affect
The Cognitive Theory of Depression
The Network Approach to Psychopathology
The Theory of Unpleasant Symptoms
Transactional Theory of Stress and Coping
Updated Review of the Infection – Defence Hypothesis
PROTECTIVE FACTORS (N=14)
Authentic happiness theory/ Well-being Theory
Attention restoration theory
Biophilia hypothesis
Broaden-and-Build theory of positive emotions
Complete state model of mental health/The Salutogenic Model
Immersive Experiences in Art
Lifestyle Factors
PERMA model
Psycho-evolutionary Stress Reduction Theory
Psychological wellbeing
Social Support
Social Capital
The ‘Old Friends’ Hypothesis
The Positivity Ratio

INTERVENTIONS (N=25)

Acceptance and commitment therapy
Behavioural activation
Broad-minded affective coping
CHIME conceptual framework for personal recovery in mental health
Cognitive Behavioural Therapy
Cognitive restructuring
Compassionate Mind Therapy
Five ways to wellbeing
Food as medicine
Guided imagery
Interpersonal Therapy
Lifestyle medicine/Therapeutic Lifestyle Change
Loving Kindness Meditation
Meta-cognitive Therapy
Mindfulness -based Cognitive Therapy
Mother-infant Psychotherapy
Motivational Interviewing
Pluralistic Therapy
Psychoeducation
Self-help/ Supported Self-Management
Structured Problem-Solving
Supportive Counselling
Supportive Psychotherapy
The Mind Model of Resilience
Trauma-informed Care

CHARACTERISTICS AND BEHAVIOR OF MOTHERS (N= 36)

Analytic rumination hypothesis
Affect labelling
Appraisal theory of emotions
Bakers model of emotional processing
Concept of maternal distress
Concept of mental health literacy
Coping styles theory
Dynamic Model of Affect
Emotional clarity
Emotional regulation
Health Action Process Approach
Health Belief Model
Hopelessness Theory of Depression
Intolerance of Uncertainty
Kleinman’s Explanatory Model of Illness
Leventhal’s self-regulatory model
Network Episode Model
Orem’s Self-Care Deficit Nursing Theory
Perceived Social Support
Perinatal Maternal Health Promotion Model
Reserve Capacity Model
Resilience Theory
Response expectancy theory
Response Styles Theory of Rumination
Self-Determination Theory
Self-Efficacy Theory
Sense of Coherence Theory
Social Baseline Theory
Social Identity Model of Identity Change
Social Rhythm Hypothesis of Depression
Social Signal Transduction Theory of Depression
Social Zeitgeber Theory
Stress Process Theory
Task shifting
‘Tend and Befriend’ Response to Stress
The Ontological Health Model

MOTHER-INFANT RELATIONSHIP (N=6)

Attachment theory
Containment
Mutual Regulation Model of Mother-infant Interaction
Newborn Behavioural Observation
Prenatal Attachment
The Touchpoints Model of Child Development

CHARACTERISTICS AND BEHAVIOR OF HEALTH PROFESSIONALS (N=17)

Activity traps
Case management
Collaborative Care/Task sharing
Common factors model
Contextual model
Integrative Mental Health Care
Neuman's Systems Model
Normalisation Process theory
Peplau's Theory of interpersonal Relationships
Person-Centred Therapeutics
Recovery Alliance Theory
Social Energy Exchange theory for Postpartum Depression
The Three Delays Model
The Three-Step Model of Shared Decision-Making
Trauma-informed Care
Uncertainty Reduction Theory
Watson's Theory of Human Caring

BEHAVIOUR CHANGE (N = 8)

Dynamic Sustainability Framework
The Adaptome
The FRAME
The Theoretical Domains Framework

CONTEXT (N=5)

The Active Implementation Framework Model
The Consolidated framework for Implementation Research
Complex systems theory
SHIFT-Evidence Framework
Social Ecological Model
Systems Thinking Theory

TOTAL NUMBER OF THEORIES = 140

One of the reasons for identifying theories is to locate points in the causal pathway where an intervention will have a disruptive effect and change the trajectory that would have led to, or maintain, the illness. As well as explaining individual factors, theories can help to explain the link between the cause, the intervention, and the factors that contribute to the effectiveness of the intervention. Some of the theories that have been identified, and the links between them, are described in more detail in the ensuing sections of this chapter. The relevance of the theories to health visiting perinatal mental health practice are discussed in section 5.4.

5.3.1. Stress, coping and social support

Several theories reference the interplay between the biological, psychological, social and cultural factors that affect maternal mental health **(EDGE & LEMETYINEN; ENGEL, 1977; HALBREICH & KARKUN, 2006; KLEINMAN ET AL, 1978; NEUMAN, 2011; OREM, 2001)**. Pregnancy initiates dramatic changes in maternal anatomy, physiology and metabolism that may be manifest as changes in maternal mental state **(GLYN ET AL, 2018)**. For example, postnatal mothers are programmed to be more alert to potential hazards and more aggressive in response to threat. These physiologically determined characteristics may be interpreted as symptoms of anxiety **(GLYN ET AL, 2018)**.

Biological theories potentially explain the relationship between stress, infant gender, birth complications, pain, inflammation, activation of the immune system, the microbiome and the development of MHPs (allostatic load theory; interoception; the circumplex model of affect; the theory of constructed emotion; the inflammatory hypothesis and cytokine theories of depression; pathogen-host defence theory of depression; social signal transduction theory of depression; 'old friend' hypothesis; the dynamic human-microbe cycle; the microbiota-inflammasome hypothesis;) **(BARRETT ET AL, 2016; BERK ET AL, 2013; DANTZER, 2001; INSERRA ET AL, 2018; KIECOLT-GLASER ET AL, 2015; LOGAN ET AL, 2016; MAES, 1995; MCEWEN, 1998; MYERS & JOHNS, 2019; POSNER ET AL, 2005; RAISON & MILLER, 2013; ROOK ET AL, 2013; SLAVICH AND IRWIN, 2014; YIM ET AL, 2015)**.

An individual's capacity to deal with stressors is determined by internal and external influences (stress process theory; reserve capacity model; sense of coherence theory). **(ANTONOVSKY 1979; COHEN &WILLIS, 1985; GALLO & MATTHEWS, 2003; PEARLIN ET AL, 1981)**. Internal influences include cognitive style, self-esteem, self-efficacy, emotional-regulation, response to stress (diasthesis-stress model) and usual coping strategies (problem- or emotion-focused). External influences include perceptions and availability of support from partners, families, social networks and health professionals **(BANDURA, 1977; BECK, 1976; COO ET AL, 2015; DENIS & LUMINET, 2018; GEORGE ET AL, 2013; GUARDINO & DUNKELSCHETTER, 2014; INGRAM & LUXTON, 2005; LAZARUS & FOLKMAN, 1984; MANN ET AL, 2004; NOLEN-HOEKSEMA, 1991; SCHWARZER, 2016; SMITH AND LAZARUS, 1993)**.

It has been suggested that 'high social support is one of the most robust correlates of better maternal mental health' **(DAVIS& NARAYAN, 2020 P.1632)**. Several theories expound the evolutionary predisposition for social contact (mismatch hypothesis of depression; evolutionary theory of loneliness; generalized unsafety theory of stress; social baseline theory; 'tend' and 'befriend' model; network episode model) and the multiple adverse consequences that can arise from the absence of supportive relationships. The changes in identity, responsibilities and opportunities for social contact consequent on motherhood (social identity model of identity change; concept of maternal distress) can culminate in 'unbearable' loneliness and symptoms of MHPs **(BECKES AND COAN, 2011; BROSSCHOT ET AL, 2018; CACIOPPO ET AL, 2014; CHENG ET AL, 2006; COAN & SBARRA, 2015; EMMANUEL & ST JOHN, 2010; HAHN-HOLBROOK & HASELTON, 2014; HENRICKSEN ET AL, 2014; IYER ET AL, 2009; PERRY AND PESCOSOLIDO, 2015; SEYMOUR-SMITH ET AL, 2017;TAYLOR, 2006)**.

5.3.2. Transition to motherhood

Cumulative exposure to traumatic experiences (Adverse Childhood Experiences (ACEs), including maltreatment as a child, can culminate in MHPs during adulthood. The psychosocial explanation is that adult symptoms of MHPs are triggered during periods of stress and transition, such as the transition to motherhood. Plant et al (2013) suggest that a history of childhood maltreatment leads to a 10-fold increased risk of antenatal depression. Unhappy childhood experiences also influence maternal mental health. Grant et al (2019) found that mothers who experienced 'maternal affectionless control' during childhood were 7x more likely to be diagnosed with PND. The biological explanation is that women who have experienced early life adversity are more likely to have higher levels of pro-inflammatory cytokines (indicating an underlying inflammatory state) and lower levels of oxytocin in response to pregnancy and motherhood and, because of this, are more vulnerable to perinatal depression **(GARFIELD ET AL, 2016)**.

According to 'Sense of Coherence' theory, life is a chaotic state to which we have to constantly adapt. An individual's sense of coherence is the capacity to make sense of the chaos, and the confidence to use external and internal resources to deal with any challenges. A coherent self views the world as comprehensible, meaningful and manageable **(ANTONOVSKY, 1979)**. Loss of control over one's body during pregnancy may predispose to anxiety. It has been proposed that strengthening 'sense of coherence' in mothers experiencing antenatal distress, by promoting acceptance, self-care and self-compassion might be beneficial **(STANEVA ET AL, 2016)**. New mothers are faced with multiple uncertainties. Intolerance of uncertainty exacerbates underlying mental health issues **(FURTADO ET AL, 2019)**.

The responsibility of looking after a vulnerable and dependent baby is a cognitively and emotionally demanding task that can lead to feelings of exhaustion, inadequacy, shame, guilt, reduced awareness of infant cues, compromised self-care and low self-esteem **(VIK AND RHONDE, 2014)**. The social energy exchange theory of postnatal depression posits that key actors in the mother's social network (including healthcare providers) can facilitate a flow of social energy to bolster maternal self-nurturance and self-compassion **(POSMONTIER & WAITE, 2011)**.

The basic psychological needs of autonomy, competence and connectedness (self-determination theory) are related to maternal perceptions of self-efficacy in their parenting role **(RYAN & DECI, 2000)**. Self-efficacy is dependent on mastery, vicarious experience, verbal persuasion and emotional arousal **(BANDURA, 1977)**. The appraisal theory of emotions states that specific emotions result from the appraisal of a situation in relation to one's own goals, concerns and well-being. Negative maternal beliefs and expectations about the future and ability to cope were the most significant appraisals found to be associated with maternal distress in a longitudinal cohort study involving 122 mothers **(COO ET AL,2019)**.

Women who are emotionally aroused may feel vulnerable and anxious about their parenting ability, or their negative thoughts might exacerbate feelings of incompetence **(BANDURA, 1977; RAZUREL ET AL, 2017)**. Emotional arousal may be manifest as 'repetitively and passively focusing on symptoms of distress and on the possible causes and consequences of those symptoms' **(NOLEN-HOEKSEMA ET AL, 2008 P.400)**. The Analytic rumination hypothesis holds that, from an evolutionary perspective, individuals with complex inter-personal problems risked ostracism from their social group so it was beneficial to focus all their attention on solving the problem **(ANDREWS &THOMSON, 2009)**.

Depression and anxiety have been described as disorders that individuals experience as a result of difficulties in regulating their emotions. Individuals with depressive symptoms have accentuated negative perceptions of themselves, their world and their future (cognitive theory of depression) **(BECK, 1976)** and are prone to rumination (response styles theory of rumination)**(NOLEN-HOEKSEMA, 1991)**. There are various theoretically informed interventions that help to reduce ruminatory thinking **(DEJONG ET AL, 2016)**. These include mindfulness and acceptance-based approaches, compassionate mind therapy and behavioural activation **(DIMIDJIAN ET AL, 2016; FONSECA ET AL, 2019; GILBERT, 2013; HAYES ET AL, 2006; KELMAN ET AL, 2018; LEAVISS & UTTLEY, 2015; RICHARDS ET AL, 2016; SEGAL ET AL, 2002; SHI & MACBETH, 2017)**.

5.3.3. Positive and negative emotions

Supporting the expression of positive and negative feelings are included in the 10 carative factors of Watson's Theory of Caring **(WAGNER, 2010)**. Helping mothers to describe how they feel is not always easy as deficits in emotional clarity (difficulties identifying emotions) are associated with multiple forms of psychopathology **(VINE & ALDAO, 2014)**. Individuals who find it difficult to identify and describe their emotions (alexithymia) experience greater difficulty in regulating their emotions. 'Affect labeling' (naming the emotion) is a basic emotion regulation strategy that has been shown to be effective in reducing distress with concurrent demonstrable changes in brain function **(LIEBERMAN ET AL, 2007; SIEGEL, 2010)**. Naming emotions facilitates processing and regulation of emotions. In a longitudinal cohort of 974 women recruited during pregnancy Wilkins (2012) found that poor emotional processing in early and late pregnancy, assessed using Baker's emotional processing scale **(BAKER, 2007)**, was strongly associated with the development of depression postnatally.

Garnefski et al (2001) propose that the default strategies used by individuals to regulate emotions can have a positive or negative effect on emotional well-being. Replacing unhelpful strategies (such as self-blame, other-blame, rumination and catastrophising) with helpful strategies (such as putting into perspective; positive refocusing; positive reappraisal; acceptance and planning) may help to ameliorate symptoms of MHPs **(ALDAO & NOLEN-HOEKSEMA, 2010; HAGA ET AL, 2012)**.

Negative and positive emotions are not necessarily opposite ends of the same spectrum but can co-exist and exert independent effects on mental health **(KEYES, 2002)**. The tripartite model of affect regulation **(GILBERT, 2005)** proposes that emotions arise as a result of the physiological consequences of activation of the reward, soothing or threat systems. Each of these systems has the capacity to de-activate the others. The deliberate stimulation of positive emotions can help to down-regulate threat-based emotions associated with psychopathology **(GARLAND ET AL, 2010; GILBERT ET AL, 2008)**. A meta-analysis of the effect of positive emotion interventions on the symptoms of depression found that they were equally efficacious and long-lasting as psychotherapy or pharmacology **(SIN & LYUBOMIRSKY, 2009)**.

Positive emotions translate the downward spiral associated with depression into an upward spiral that leads to expanded attention, thinking and creativity **(GARLAND ET AL, 2010)**. The increased cognitive flexibility associated with positive emotions facilitates 'task shifting' (ability to switch rapidly between multiple goals), an essential task of motherhood **(WANG ET AL, 2017)**. Non perinatal mental health participants randomized to a 7 week intervention designed to increase daily experience of positive emotions reported increases in 9 positive emotions (joy, contentment, amusement, awe, gratitude, interest, hope, pride and love), improvements in social relationships, and reductions in symptoms of depression, compared to a waitlist control group **(FREDERICKSON ET AL, 2008)**. Strategies to increase experiences of positive emotions include broad-minded affective coping **(TARRIER, 2010)**, Guided imagery **(JALLO ET AL, 2014)**, expressing gratitude, counting blessings and practicing kindness **(BOLIER ET AL, 2013)**.

The salutogenic model, the ontological health model, the perinatal maternal health promotion model, the complete state model of mental health, the Mind model of resilience and the broaden-and-build theory of positive emotions all draw attention to the continuum of health-disease and the multiple ways to prevent and treat mental illness and promote emotional well-being **(ANTONOVSKY, 1978; FAHEY AND SHENASSA, 2013; FREDERICKSON & JOINER, 2002; FREDERICKSON &LOSADA, 2005; GARLAND ET AL, 2010; KEYES, 2002; LARSSON ET AL, 2016; ROBINSON ET AL, 2014)**. Keyes (2016 p.101.) states that 'Even if we could find a cure for mental illness tomorrow, it does not mean that most people would necessarily be flourishing in life. In other words, we cannot treat our way out of the problem of mental illness, we must also promote a life of balance in which people can achieve happiness and realize lives in which they can flourish.'

5.3.4. Lifestyle factors

Kazdin and Blase (2011) suggest that it may be beneficial to offer low-cost, easily accessible interventions even though there may be less robust scientific validation of their effectiveness. For an intervention to be salutogenic (health promoting) it has to be meaningful, comprehensible and manageable to the individual **(AYERS, 2017)**. Simple techniques that do not require too much effort, or persistence to achieve results, are particularly relevant for depressed individuals who may be tired, time poor, have difficulty concentrating and lack motivation **(GERAGHTY ET AL, 2016)**. Patients with sub-threshold symptoms of depression rate lifestyle and psychosocial interventions as the most helpful in improving their mood **(MORGAN & JORM, 2009)**.

5.3.4.1. SLEEP

Both the network approach to psychopathology and the theory of unpleasant symptoms suggest that mental disorders arise from interactions between symptoms **(BORSBOOM, 2017; LENZ AND PUGH, 2003; SANTOS ET AL, 2018)**. Targeting one focal symptom may have a knock-on beneficial effect on other symptoms **(GIALLO ET AL, 2016)**. For example, sleep deprivation is a commonly experienced 'hassle' of early motherhood **(DIPIETRO ET AL, 2015)**. Disrupted or fragmented sleep affect other physiological processes influenced by circadian rhythms **(LOGAN & JACKA, 2015)**. Disrupted sleep can be a cause or consequence of anxiety or depression.

Sleep deprivation leads to poor concentration, poor memory, fatigue/low energy, lack of motivation, more negative interpretations of words and facial expressions, increased perceptions of loneliness, and social distancing from others **(WALKER, 2017; BEN SIMON AND WALKER, 2018)**. Social distancing from others can compromise the availability of emotional and practical support. Lack of support triggers increased alertness for threats to safety that requires intense neural effort **(CACIOPPO ET AL, 2014)**. This leads to reduction in blood glucose levels and a craving for carbohydrates **(HENRIKSEN ET AL, 2014)**. Fatigue predisposes to poorer food choices **(KIECOLT-GLASER ET AL, 2015)**. Poorer food choices include low fibre, high fat, high sugar diets that are associated with less restorative sleep and more arousals **(PRESCOTT & LOGAN, 2016)**, further aggravating the underlying issue of disrupted sleep. Exploring strategies to address sleep deprivation and fatigue may reduce the likelihood of development of other symptoms **(DOERING 2013; GIALLO ET AL, 2016; TROY & DALGAS-PELISH, 2003)**.

5.3.4.2. NUTRITION

The Global burden of disease study 2013, identified unhealthy diet as a leading cause of mortality worldwide **(COLLABORATEURS GDFR ET AL, 2015)**. This includes the diets of mothers during pregnancy and after the baby is born. Many mothers in industrialised countries consume high calorie, nutrient-poor diets **(CETIN & LAORETI, 2015)**. In a meta-analysis of 62 studies (from the USA, Canada, UK, Europe, Australia, new Zealand and Japan) folate, iron and vitamin D intakes in pregnant women were consistently below nationally recommended levels **(BLUMFELD ET AL, 2013)**. The quality and variety of the food, and patterns of eating, are as important as the nutrient content **(OPIE ET AL, 2015)**.

Mental disorders are also a leading cause of global disability **(VIGO ET AL, 2016)**. The International Society for Nutritional Psychiatry Research advocates that nutritional factors (such as nutrient content and diet quality) should be included in an integrated approach to the assessment, treatment and prevention of MHPs **(SARRIS ET AL, 2015)**. As diet is a variable with 100% exposure, even slight improvements in depression as a result of dietary interventions may translate into significant benefits at a population level **(DASH ET AL, 2016; JACKA ET AL, 2017)**.

A meta-analysis of the association between diet quality and depression found that 'A dietary pattern characterized by high intakes of fruit, vegetables, whole grain, fish, olive oil, low-fat dairy and antioxidants and low intakes of animal foods was apparently associated with a decreased risk of depression. A dietary pattern characterized by a high consumption of red and/or processed meat, refined grains, sweets, high-fat dairy products, butter, potatoes and high-fat gravy, and low intakes of fruits and vegetables is associated with an increased risk of depression.' **(LI ET AL, 2017 P.373)**.

A prospective cohort study involving 529 pregnant women indicated that a Mediterranean style diet reduced the likelihood of PND **(CHATZI ET AL, 2011)**. Inconsistent associations between dietary patterns/ nutrient content and maternal mental health have emerged from other studies. A 'healthy' maternal diet is still worth advocating based on the burgeoning problem of perinatal obesity; the bi-directional relationship between obesity and mental health; the evidence of benefits to maternal physical health; and the relationship between maternal diet and the cognitive and emotional development of maternal offspring **(ENTRINGER ET AL, 2015; JACKA ET AL, 2013; LOPRESTI & DRUMMOND, 2013; O'NEIL ET AL, 2014; STEENWEG- DE GRAAF ET AL, 2014)**.

5.3.4.3. EXERCISE

A study involving 15 European countries found a positive association between physical activity and self-reported levels of happiness **(RICHARDS ET AL, 2015)**. A systematic review and meta-analysis of the benefits of aerobic exercise for mothers with PND concluded that exercise, given its easy access and low-cost, should be recommended to treat and prevent PND **(PRITCHETT ET AL, 2017)**. Improvement in mood may be achieved within 10 minutes of commencing a single session of exercise **(MORETON, 2018)** and within 5 minutes if the exercise is taken in a green space **(BARTON AND PRETTY, 2010)**. Exercise in natural environments improves mental health **(BOWLER ET AL, 2010; COON ET AL, 2011; MCMAHON & ESTES, 2015; MITCHELL, 2013)**.

5.3.4.4. IMMERSIVE EXPERIENCES IN NATURE

The biophilia hypothesis, psychoevolutionary stress reduction theory and attention restoration theory all attest to the human preference for natural landscapes, even if they are only pictures of nature **(KAPLAN & BERMAN, 2001; KELLERT & WILSON 1993; ULRICH, 1981)**. In one study, functional magnetic resonance imaging showed increased activity in areas of the brain linked to impulsivity and anxiety when individuals observed urban scenes, and increased activity in areas of the brain linked to emotional stability when rural scenes were observed **(LOGAN & SELHUB, 2012)**.

Individuals who have to maintain focused attention on a task (such as mothering) for a prolonged period of time become mentally fatigued. Environments with naturally fascinating stimuli reduce the need for focused attention and have a restorative effect on cognitive function and emotional well-being **(KAPLAN & BERMAN, 2001)**. Alternative ways of obtaining relief from the mentally and emotionally demanding task of looking after a new baby include 'time for self'. In a prospective cohort study, mothers who had at least one hour/week of 'time for self' in the first 6 months postpartum were less likely to report depressive symptoms than those who did not **(WOOLHOUSE ET AL, 2016)**.

Immersive experiences in nature confer multiple benefits **(BERMAN ET AL, 2008; BRATMAN ET AL, 2015; HARTIG ET AL, 2014; LI 2010; MORITA ET AL, 2007)**. A dose-response relationship has been found between visits to green spaces of at least 30 min/week and reductions in symptoms of depression **(SIN ET AL, 2015)**. Pregnant women living in greener environments are less likely to report symptoms of depression **(MCEACHAN ET AL, 2016)**. Whilst it might not be possible for HVs to change maternal residential proximity to green space, they can encourage time in contact with nature.

5.3.4.5. DAYLIGHT

Simple strategies like exposure to morning daylight and implementation of regular daily patterns of activity (social rhythm hypothesis) that help to re-establish disrupted circadian rhythms (social zeitgeber theory) have also been implicated in the prevention or amelioration of symptoms of MHPs **(EHLERS, 1988)**. The increased prevalence in PND in women exposed to less daylight as a result of seasonal variation in day length supports the relevance of daylight for maternal mental health **(GOYAL ET AL, 2018)**.

A UK Biobank study involving over 90,000 adults found that disruptions in circadian rhythms (less activity during wakeful periods and more activity during rest periods) evidenced by daily wearing of wrist accelerometers for 7 days was associated with greater mood instability, lower happiness, more subjective loneliness and decreased life satisfaction **(LYALL ET AL, 2018)**. Disruption in the circadian rhythmicity of physiological processes in the postpartum period, combined with an unhealthy diet, may adversely influence the gut microbiome with the knock on effects of decreasing the amount of neurotransmitters (normally produced by gut bacteria) and increasing gut permeability, both of which are linked to

an increased risk of depression, anxiety and psychosis **(BASTIAANSSEN ET AL, 2019; LOGAN ET AL, 2016; MADISON & KIECOLT-GLASER, 2019)**. Establishing a routine also reduces stress by helping mothers to manage the uncertainty and loss of control imposed by the unpredictability of infant demands.

5.3.4.6. IMMERSIVE EXPERIENCES IN ART AND CREATIVE EXPRESSION

Participating in some form of artistic expression or observing the artistic expression of others can improve mood, psychological function and physical well-being **(JENSE & BOND, 2018)**. The main therapeutic modalities emerging from a literature review on art and healing are music, visual arts, movement-based creative expression, and expressive writing **(STUCKEY AND NOBEL, 2010)**. An All-Party Parliamentary Group (APPG) Inquiry into the arts and health recommended that art initiatives should be incorporated into commissioning plans and care pathways of health and social care providers **(APPG, 2017)**.

Adult colouring books and other opportunities to use the imagination, such as creating Mandala circles have been shown to have a positive effect on mental health **(BABOUCHKINA & ROBINS, 2015; FLETT ET AL, 2017; HENDERSON, 2012)**. Attendance at a 10-week singing group led to speedier recovery from mild to moderate PND, compared with usual care **(PERKINS ET AL, 2018)**. In a cross-sectional study, mothers who reported singing to their babies on a daily basis had fewer symptoms of postnatal depression and higher levels of well-being and self-esteem compared to mothers who sang to their babies less frequently **(FANCOURT &PERKINS, 2017)**. A Taiwanese study showed reductions of anxiety, stress and depression in pregnant women who listened to 30 minutes of relaxing music every day for two weeks **(CHANG ET AL, 2008)**.

5.3.5. Interventions

Uncertainty reduction theory and the three delays model emphasise the importance of providing information to mothers about what the HV can offer in terms of support as well as the range of support that is available **(BERGER AND CALABRESE, 1975; EASTER ET AL, 2019)**. Ensuring mutual understanding of maternal beliefs about causes, consequences and management of symptoms enhances the probability of meaningful outcomes **(HEALTH BELIEF MODEL; THEORY OF PLANNED BEHAVIOUR; HEALTH ACTION PROCESS APPROACH) (AIZEN, 1988; ROSENSTOCK,1974; SCHWARZER, 2016)**. Peplau's theory of interpersonal relationships, Watson's Theory of Caring, Recovery Alliance Theory and the Common Factors Model draw attention to the process of developing, sustaining and ending collaborative, empowering, authentic, caring relationships that enable shared decision-making and individualized plans of care **(EVANS ET AL, 2017; PEPLAU,1952; SHANLEY & JUBB-SHANLEY, 2007; TEKTAŞ & ÇAM, 2017; WAGNER, 2010)**.

The diversity of symptom aetiology and expression and the uniqueness of individuals demands a pluralistic, responsive, integrative approach to treatment that could involve the use of multiple strategies and techniques **(COOPER & MCCLEOD, 2011; SARRIS ET AL, 2014)**. A range of strategies/techniques/interventions have been identified that have been used to treat maternal MHPs . The list presented in 5.2. is probably not an exhaustive one and provides further evidence of the challenges of attempting to elucidate the theories that might help to inform a HV intervention. Despite the different descriptive terms for specific therapeutic interventions analysis of their theoretical foundations does reveal similarities in their intended focus or mechanism of action (see table 5.3).

TABLE 5.3. THE THEORETICAL RATIONALE FOR SPECIFIC PSYCHOLOGICAL INTERVENTIONS AND THEIR RELEVANCE TO PERINATAL MENTAL HEALTH CARE

INTERVENTION	RATIONALE AND RELEVANCE TO PERINATAL MENTAL HEALTH CARE
Acceptance and Commitment Therapy (HAYES ET AL, 2006).	Mothers, at risk of developing PND, are less likely to develop PND if they are more accepting of negative thoughts, unpleasant feelings and unexpected emotions (FONSECA ET AL, 2019).
Behavioural activation (BA) (VEALE, 2008).	Clinically significant improvement in symptoms of stress, anxiety and depression was noted at 3 months follow-up in pregnant mothers, with symptoms of depression, who received a BA intervention consisting of structuring and scheduling activities, problem solving, and increasing social support (DIMIDJIAN ET AL, 2017).
Cognitive Restructuring	Cognitive restructuring was defined as becoming aware of one's thoughts to identify and label those which are helpful and unhelpful, and modify the unhelpful ones into more helpful ones, thereby improving symptoms of depression.
Compassionate Mind Therapy	Internet Compassionate Mind Therapy, seeking to replace self-criticism and self-blame with curiosity about how our minds work and a deliberate focus on what might be helpful to self and others, reduced symptoms of anxiety and depression in perinatal women (KELMAN ET AL, 2018).
Interpersonal Therapy	The purpose of this therapy is to resolve interpersonal issues relating to role transition, role dispute, grief and interpersonal deficits. Research indicates that this therapy leads to improved relationships with partners and babies and reduced symptoms of depression in mothers (MINIATI ET AL, 2014; SOCKOL ET AL, 2011).
Meta-Cognitive Therapy	Strategies are introduced to help postnatally depressed mothers to overcome their focus on their thoughts (rumination, excessive worry) (BEVAN ET AL, 2013).
MIND Model of Resilience	According to a scoping review of resilience theories in the transition to parenthood, resilience supporting factors include 'positive self-concept; optimism; social support; family relationships; community services; and social connectedness (YOUNG ET AL, 2019).

INTERVENTION	RATIONALE AND RELEVANCE TO PERINATAL MENTAL HEALTH CARE
Mindfulness/Mindfulness based Cognitive Behavioural Therapy (CBT)	Results of a systematic review and meta-analysis indicate that mindfulness interventions (cultivations of non-judgemental, present-centred awareness in which thoughts, feelings and sensations are accepted just as they are), may be a beneficial and acceptable strategy for pregnant women.
Motivational Interviewing	Motivational interviewing helps individuals to resolve ambivalence and plan for change. This technique has been used to help depressed mothers to engage with an intervention **(HOLT ET AL, 2017).**
Psychoeducation	In a systematic review of the content and delivery of psychological interventions for perinatal depression, psychoeducation referred to 'information about symptoms and the likely causes, offering hope and motivating women to seek appropriate treatment' **(CHOWDHARY ET AL, 2014 P.121).**
Supportive counselling/Non-Directive counselling/Person-centred care	6 conditions necessary for therapeutic change: therapist-client psychological contact; client incongruence; therapist genuineness; unconditional positive regard; empathic understanding; the client perception that the therapist has these qualities. Supportive counselling offered by Public Health Nurses to mothers with PND at 6 weeks post-partum led to improvements in depressive symptoms at 3 and 6 months post-partum **(GLAVIN ET AL, 2010).**
Supportive Psychotherapy	A variety of techniques (active listening, encouragement, praise, reassurance, expanding the patient's awareness, reframing, anticipatory guidance) are used to ameliorate symptoms, improve functioning, or help bolster an individual's ability to deal with a crisis or transient problem **(GOODMAN ET AL, 2015).**
Supported Self-Management	Supported self-management involves action planning to change behaviour. Techniques include behavioural activation, communication skills, coping with emotion, patient education, healthy lifestyle, relapse-prevention planning, skill development and self-monitoring **(LAM ET AL, 2016).**
Structured Problem-Solving	Problem solving consisting of problem orientation, problem definition and formulation, generation of alternatives, decision making, and verification was identified as an effective strategy in a systematic review of treatments for perinatal depression **(CHOWDHARY ET AL, 2014).**

INTERVENTION	RATIONALE AND RELEVANCE TO PERINATAL MENTAL HEALTH CARE
Trauma-informed Care	All health professionals should assume that all adults might have experienced trauma. All care should embrace the principles of trauma-informed care: compassion and recognition; communication and collaboration; consistency and continuity; recognising diversity and facilitating recovery. Trauma-informed care aims to generate feelings of safety, choice and control. 8 'A's of a supportive response to disclosure of trauma are ask, acknowledge, assess, assume, avoid, arrange, advocate, ascertain **(LAW ET AL, 2021)**.

5.3.6. The therapeutic relationship

Selection of appropriate strategies relies on the development of a shared understanding of what the problem is and how it can be treated. The contextual model holds that, for interventions to be effective, they must include a cogent rationale that is accepted by the client, a therapist who believes the treatment will be effective, and a client who is willing to engage in health promoting actions that lead to the changes that they want to see in their lives **(WAMPOLD & IMEL, 2015)**. Both the recipient and the provider have to believe that engaging with the intervention is worth the investment of their time and energy and will culminate in beneficial outcomes.

The content and quality of the interaction between the patient and the health professional is also influenced by their respective perceptions of each other's reasons for making a connection and their prior knowledge of each other. The evidence underpinning the NICE guideline for antenatal and postnatal mental health **(NCCMH, 2014)** states that specific interventions to address mental health issues may be offered within the context of a more comprehensive treatment programme or package of support. This is relevant to the role of the HV in terms of integrating the assessment and intervention of MH issues within the framework of the Healthy Child Programme **(DH, 2009)**, but also resonates with the concepts of integrative mental health care **(SARRIS ET AL, 2014)**, case management **(ROSS ET AL, 2011)**, and collaborative care **(GROTE ET AL, 2015)**.

The success of any intervention is influenced by the beliefs, skills, knowledge, qualities, assumptions, motivation, capacity, experience and behaviour of both the provider and recipient of the intervention **(LAU ET AL, 2015)**. When seeking to re-design an intervention, understand why or how it has been modified, or ensure its sustainability, it is advisable to have an idea of the factors that are likely to facilitate or compromise optimal engagement and enhance or undermine optimal delivery **(ATKINS ET AL, 2017)**. Various theories, models and frameworks have been developed to explain the psychological, social or structural processes that influence health professional behaviour and behaviour change **E.G. THE DYNAMIC SUSTAINABILITY FRAMEWORK, THE ADAPTOME, THE FRAME, THE THEORETICAL DOMAINS FRAMEWORK (ATKINS ET AL, 2017; CHAMBERS & NORTON, 2016; MOULIN ET AL, 2015; WILTSEY STIRMAN ET AL, 2019)**. As the Theoretical Domains Framework (TDF) is used in Chapter 7 to frame the analysis of the responses to the survey set up to examine current practice and context, consideration of the factors influencing the behaviour of HVs will be deferred to that chapter.

5.3.7. Context

Context refers to anything in the proximal environment of the recipients and providers of interventions that might have a bearing on the feasibility, acceptability or effectiveness of the intervention. In an acknowledgement of general systems theory **(FANJIANG ET AL, 2005)** Wight et al (2016), point out that re-designing interventions are disruptive events that alter relationships, displace entrenched practices and re-allocate resources. For an intervention to be successfully adopted and sustained, change is therefore needed throughout the complex system of healthcare delivery **(ABLETT, 2019; HAWE ET AL, 2009)**. The challenge lies in harnessing the energy within the complex system (that exists between rigidity and chaos) to integrate the component parts in seamless, collaborative care culminating in synergistic benefits for mothers and families **(CONNELLY ET AL, 2010; GROTE ET AL, 2015; SIEGEL, 2019)**.

The range of theories that explicate the importance of context have been alluded to but have not been described in great detail. This is not because context is not an important consideration. NICE (2007) behaviour change guidance recommends that intervention designers expand their horizons to draw on a wider range of theories and consider targeting variables at different levels (individual, community and population).

Damschroder et al (2009) integrated evidence from multiple sources to develop the Consolidated Framework for Implementation Research (CFIR). The framework is designed to identify factors that influence implementation of healthcare interventions and is organised into five domains. These are intervention characteristics, outer setting, inner setting, characteristics of individuals and process. The majority of these components will be explored in Chapter 7 as there is a certain amount of overlap between the domains of the CFIR and the domains of the TDF.

5.4. Discussion

The purpose of this literature review was to identify theories that would enhance understanding of the factors that prevent, cause, aggravate or appease maternal MHPs that might be particularly relevant to the re-design of HV perinatal mental health intervention.

As a theory is a system of ideas that is meant to try and explain something, it is inevitable that trying to explain how a complex intervention might work in a complex system that is in a constant state of flux, would result in a multitude of theories that may be relevant some of the time, in some situations, and when a particular set of circumstances prevail.

The selection of appropriate theories is influenced by the purpose of the inquiry and the perspective of the inquirer. It is unlikely that all the theories that I have identified as relevant to the re-design of a HV perinatal MH intervention will be seen as equally relevant to other individuals who have different professional backgrounds, experience and expectations.

The biological evidence suggesting a relationship between inflammation, the immune system, the stress response system and the microbiome requires HVs to understand the potentially synergistic influences of these complex factors on physical and mental health. This emphasises the importance of a comprehensive and ongoing assessment of maternal mental and physical health and the need to tailor interventions to address underlying causes of mental distress.

Assessment should incorporate consideration of the range of biopsychosocial factors that enhance vulnerability or promote resilience. This should include a review of maternal and family resources, social networks and usual coping strategies. HVs need to be able to make sensitive enquiries about maternal experiences of adverse childhood experiences or traumatising events in adulthood and understand that these aspects of personal history can lead to difficulties in forming and sustaining close relationships, and an increased likelihood of health-harming, self-soothing behaviours and MHPs during adolescence and adulthood.

The theories that explicate different sources of stress and ways of coping further highlight the need for a comprehensive assessment of need, symptoms and circumstances, as early as possible in the antenatal period. HVs need to be particularly aware of the 'unbearable loneliness' that some mothers experience and the relationship between fractured sleep, disrupted circadian rhythms, social isolation and depression.

HV interventions for MHPs should seek not only to provide relief from symptoms (including blunted or heightened emotional arousal) but, in order to enhance a sense of mastery, also provide anticipatory guidance on maternal self-care, maternal-infant interaction and infant development, behaviour, communication, and care **(GOODMAN ET AL, 2015; NUGENT ET AL, 2014; NUGENT ET AL, 2017; SHOREY ET AL, 2015; TRONICK, 2007; WORLD HEALTH ORGANISATION, 2018)**.

The beneficial impact of lifestyle modifications on mental health has been underestimated **(ILARDI, 20009; MORTON, 2018; SARRIS ET AL, 2014A; WALSH, 2011)** and neglected by mental health professionals **(SARRIS ET AL, 2014B)**. Increased contact with health visitors during the perinatal period provides opportunities to ameliorate the potential impact of unhealthy lifestyles on maternal mental health and promote the benefits of the range of factors that promote optimal physical and mental health **(DE WEERTH, 2018)**.

There are theories that suggest that an equal focus on promoting positive thoughts and emotions might help to both promote emotional wellbeing and treat symptoms of psychological distress. Several strategies and techniques have been identified that could be included in a HV intervention such as motivational interviewing, structured problem-solving and behavioural activation. In order to engage with any intervention, the mother needs to feel that the HV is someone whom she can talk to, who acknowledges the uniqueness of her distress and who will help her to identify achievable goals and the interventions that will help her to reach them. Establishing a supportive, trusting relationship is therefore an essential prerequisite of effective engagement.

5.5. Strengths and Limitations

The purpose of this literature review was to identify or develop the theory that could inform the re-design of LVs. Both Ayers and Olander (2013) and Campbell et al (2014) have highlighted some of the challenges of finding relevant theories. There is an expectation that complex interventions delivered in complex systems will need a range of theories to inform or explain the key features of delivery **(TSOUKAS, 2017)**. The number of theories identified in this review made it quite difficult to find supporting evidence to confirm their relevance to perinatal mental health, and to integrate them into a cohesive and meaningful narrative, that will help to inform intervention development.

Ayers & Olander (2013) acknowledge that there are probably many theories from multiple disciplines and perspectives that might be relevant to answer the question 'What are we measuring and why?' but then explore the advantages and disadvantages of using theories to inform perinatal mental health practice with reference to only 4 categories of theory. Reeves et al (2008) suggest that 'Theories are intended to provide complex and comprehensive conceptual understandings of things that cannot be pinned down' **(REEVES ET AL, 2008 P.631)**. Maybe the 'truth' that we need to see is that there are just too many theories that might be relevant, and therefore they are too difficult to pin down.

Whilst the review reported in this chapter confirmed Ayers & Olanders' (2013) expectation that many theories might be relevant in perinatal mental health interventions, a study by Evans et al (2020) involving the use of the MRC guidance to inform the development of an intervention for antenatal anxiety only referenced 5 categories of theory to inform intervention design. The theories were derived from a prior systematic review of effective interventions for antenatal anxiety conducted by the same research team **(EVANS ET AL, 2018)**. The conclusion of the systematic review was that there was insufficient evidence to draw overall conclusions regarding the benefit of the reviewed interventions. Although the evidence from the systematic review indicated that there was insufficient evidence of effectiveness of included studies, the theoretical rationale for the components included in the studies was used as the basis for the theoretical foundation for the development of a new multicomponent intervention to treat antenatal anxiety. According to this research team, the rationale for the intervention remains even if the actual intervention does not lead to beneficial outcomes **(EVANS ET AL, 2020)**. Hawe et al (2004) suggest that complex interventions should be defined according to what they are expected to achieve (theoretical foundation) to allow interventions to be adapted to suit local contexts. However, this still might be a challenge if the identification of appropriate theories continues to be so elusive.

5.6. Conclusions

Birken et al (2017 p.2) state that 'the underuse, superficial use, and misuse of theories pose a substantial scientific challenge for implementation science'. Birken et al (2017) sought the views of implementation scientists about the process they used to identify relevant theories and concluded that the process was often haphazard, driven by convenience or influenced by prior exposure to particular theories. A similar picture emerges from a systematic review of methods designed to facilitate the transfer of research knowledge into practice by changing the behaviour of health professionals. Colquhoun et al (2017) state that knowledge translation efforts are hampered by haphazardly designed and poorly specified interventions, with theory hardly ever being used to inform intervention design.

Whilst knowing how an intervention is supposed to work is a laudable ambition, it would appear that making it meaningful, through an explication of the theories that might be relevant, is difficult to achieve in practice.

Nevertheless, by searching the literature many theories have been identified that might help to inform or explain the support that HVs provide to mothers with MHPs. Even though the specificity of the theories might be open to challenge, from a Gadamerian perspective, the process of searching for them has added an additional dimension to my thinking, does provide some useful insights about potentially important elements of a HV intervention, and has extended the limits of my horizon, by making me think beyond what I already know.

Some of the strategies, techniques and implementation processes identified in this chapter are comparable to those identified in the previous chapter as a result of the extraction of common elements from effective interventions. Every stage of this research is connected to every other and serves to stimulate a process of constant comparison, reflection and iteration in a hermeneutic circle of interpretation.

Having identified the common elements and key implementation processes of effective interventions (Chapter 4) and explored the theories that might help to inform the content of a HV intervention (this chapter), the next stage (reported in the next chapter) is to find out what mothers and health visitors think are the essential components and active ingredients of an appropriate, acceptable and feasible perinatal mental health intervention. As the research progresses the elements that emerge as possible components of an HV intervention will be assimilated so that they can be presented to a group of expert HVs during the course of a real-time, modified technological Delphi study in the penultimate stage of the research process.

5.7. Chapter summary

This chapter has illustrated the challenges of identifying or developing theories that might help to inform or explain a HV intervention designed to treat mothers with mild to moderate MHPs. The complexity of delivering a complex intervention in a complex healthcare system has exposed the many facets of intervention delivery that need to be taken into account and the potential for the discovery of an exponentially expanding number of theories that might be relevant, but increasingly unmanageable. However, as a result of a combination of search methods, 140 theories were extracted from 307 articles to illuminate the causes; symptoms; protective factors; interventions; characteristics and behaviours of mothers and health professionals; and aspects of behaviour change and context that might be relevant to a re-designed HV intervention.

Chapter 6. Determining the Needs of Providers and Recipients

6.1. Introduction

Previous chapters have focussed on the nature of the problem that needs to be addressed; the theories that inform the actions needed to disrupt the causal pathways that lead to perinatal MHPs; and the commonly occurring components of effective interventions that could be incorporated into a HV perinatal mental health intervention.

Even if there is a logical explanation as to why interventions should work and evidence that interventions delivered in a specific way, by highly trained professionals, to a carefully selected group of patients are effective, there is no guarantee that the same results will be achieved when the intervention is transferred to the real world of clinical practice. For interventions to work they have to be acceptable to the practitioners expected to deliver them and the recipients expected to benefit from them. Referring to the fourth stage of the enriched development phase of the MRC guidance, Bleijenberg et al (2018) state that 'A thorough understanding of the needs, perceptions, preferences, and capacities of the recipients, as well as the providers, is a fundamental element that needs to be incorporated into the development process' (p.90).

The purpose of this chapter is to explore the perceptions and experiences of providers (HVs) and recipients (mothers) of perinatal mental healthcare. The method chosen to achieve this objective is a synthesis of quantitative and qualitative literature guided by a hermeneutic perspective that seeks to capture the uniqueness and diversity of lived experience and minimise the 'representational' gap. This refers to the 'crisis of representation' whereby the act of thematic synthesis by the researcher distorts the original meaning of the participants' narratives **(SANDELOWSKI, 2006)**. Meta-syntheses of qualitative research add another layer to the distortion, so that the final synthesis is the reviewer's interpretation, of the researchers' interpretations, of what the participants in the primary research 'said', which might not be a true reflection of what they thought or meant! **(SANDELOWSKI, 2006)**. The risk is that instead of giving 'voice to the voiceless', a meta-synthesis represents the successively refined views of the researchers and is divorced from the novel insights to be gained from the authentic contributions of research participants **(SANDELOWSKI, 2006. P.10)**.

In hermeneutic inquiry, the researcher needs to be open to what might be new, different or surprising. Gadamer wrote about the fecundity of the individual case – 'even a single, specific experience of a complex intervention may shed new and transformative light on an aspect of the intervention that could further an understanding of the whole intervention' **(THIRSK & CLARK P.5)**. The analysis of the literature included in this chapter will therefore focus on maintaining the uniqueness of individuals whilst also thinking deeply and creatively about how to present the data in a meaningful way. Qualitative synthesis is not about truths but ideas – 'ideas that will enlighten, enrich, elaborate, and enhance the understandings with which one approaches real-life problems in the health arena, advancing, rather than stifling deep searching and reflective thinking' **(THORNE, 2019. P.5)**. This chapter will attempt to interpret the accumulated wisdom of mothers and HVs, derived from the literature, whilst retaining the essence of their authentic contributions.

The rest of this chapter provides a further explanation of the rationale for the method chosen to select relevant literature, a summary of the key features of selected articles, and an analysis of the implications of the views and experiences of mothers and health visitors for health visiting perinatal mental health practice. The strengths and limitations of a hermeneutic literature review are re-visited. Conclusions drawn include the relative lack of research about the views and experiences of HVs and the need for

a greater emphasis on the importance of establishing collaborative and trusting relationships not only between health visitors and mothers, but amongst all the professionals who are involved in the perinatal mental health pathway of care.

6.2. Method

A more formal approach for conducting a qualitative metasythesis was initially undertaken that included clarification of the parameters of the investigation using PICOs criteria, MESH terms, systematic searching and critical appraisal **(LACHAL ET AL, 2017)** but, on reflection, and having been particularly influenced by the work of Moules, Peck, Sandelowski and Thorne, I felt that this approach was not in keeping with a hermeneutic orientation **(MOULES, 2002; PECK, 2012; SANDELOWSKI, 2006; THORNE 2017 & 2019)**.

Hermeneutic literature searches should be open-ended and iterative allowing for the development and honing of the topic under review as more articles are identified and greater insight is acquired **(FINGFELD-CONNETT & JOHNSON, 2013)**. Smythe & Spence (2012) suggest that a literature review is an ongoing dynamic process that continues before, during, and often beyond, engagement with a research study. Just as the information that we have access to, that might be considered relevant to the focus of our inquiry, is in a constant state of flux, a literature review should be perceived as a dynamic process that is constantly being re-visited and re-interpreted. Continual exposure to literature for the duration of the study, as well as immersion in the topic from multiple perspectives, helps to generate a greater depth of understanding and more opportunities to re-visit and re-evaluate personal assumptions and beliefs.

The hermeneutic literature review that began with the identification of a cache of articles, that cited the seminal Holden et al (1989) article, has evolved in different directions according to the requirements of each stage of the research. A systematic approach has been deployed to identify a cache of relevant articles to provide the starting point for this review. The purpose of the review was to extract the findings that would give 'meaning' to the way perinatal mental ill-health interventions are experienced in order to consider how an intervention delivered by HVs might be improved **(NOYES & LEWIN, 2011)**.

Of the 449 articles that were identified in the original Google scholar search, using the Holden et al (1989) article as the pearl citation, 33 investigated the views of mothers and 7 investigated the views of health professionals. These provided the starting point for this review. Four of these articles were chosen to act as a 'pearl' for further searches using Google scholar: two articles were used as the citation 'pearls' to identify articles relevant to the views of mothers and two articles were used to identify articles relevant to the views of health visitors. The 'pearl' articles were chosen because they specifically focussed on LVs. It wasn't always possible to exclusively focus on the experiences of HVs but articles were only included if they made reference to the experiences of healthcare providers operating in the primary care space. Other articles were subsequently included if they investigated experiences of perinatal mental illness and care of antenatal and postnatal mothers, or the experiences of HVs (or their equivalent) of providing perinatal mental healthcare. Qualitative, quantitative or mixed methods studies were included if the target population included mothers' resident in the UK, or HVs/Public Health Nurses working in the UK. Additional articles were identified though ancestry searching, citation tracking, journal alerts and serendipitous discovery. Grey literature was identified and included in the review if it helped to 'enrich' understanding of the experiences of mothers and HVs. The review was expansive rather than exhaustive and, owing to the circuitous nature of the search, cannot be portrayed in the conventional PRISMA flow diagram **(FINGFELD-CONNETT & JOHNSON, 2013)**. See Fig 6.1 for a diagrammatic depiction of the preliminary stages of the hermeneutic literature review process.

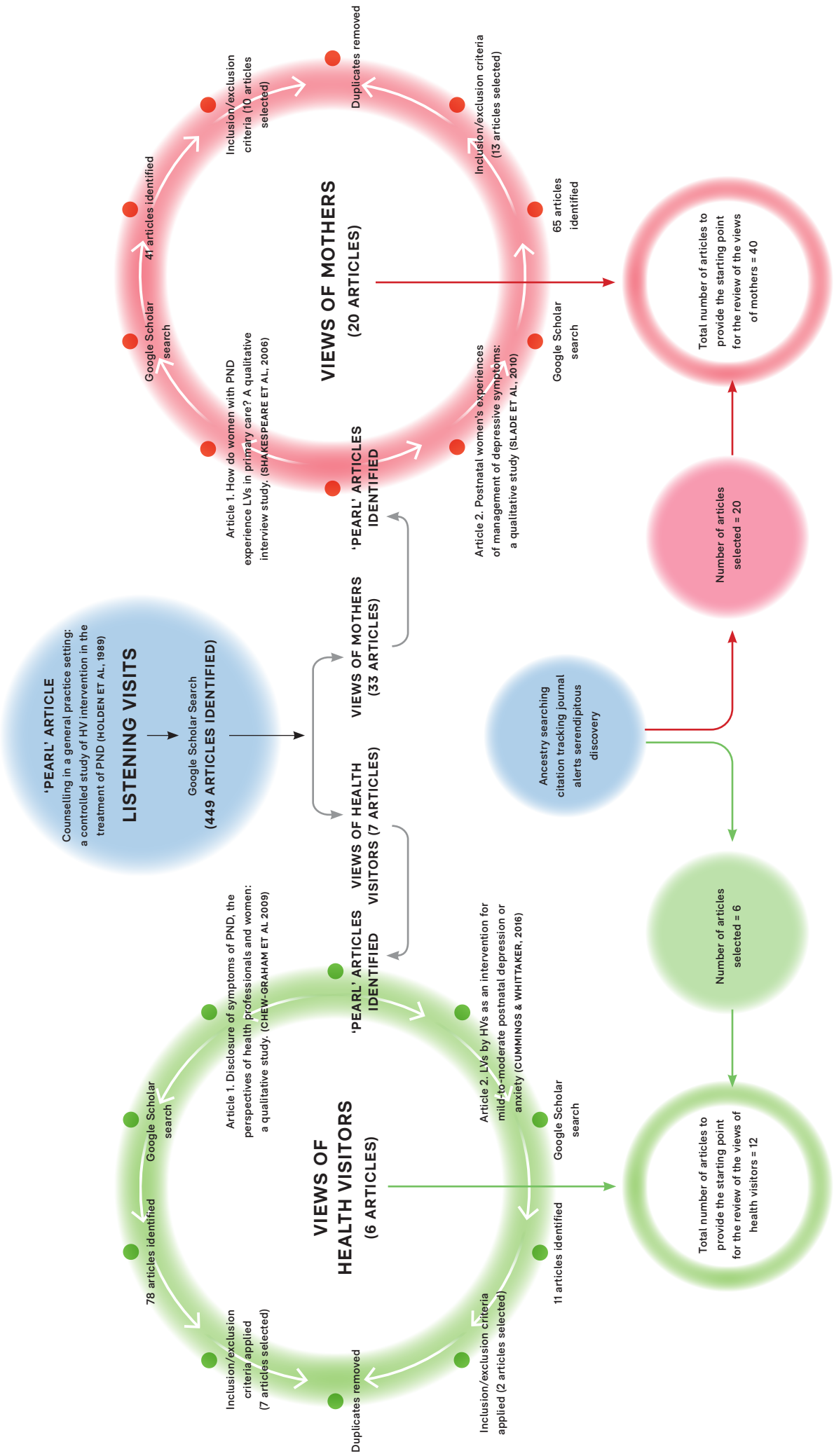


FIG 6.1 DIAGRAMMATIC REPRESENTATION OF THE SYSTEMATIC PROCESS OF A HERMENEUTIC LITERATURE REVIEW TO ENABLE IDENTIFICATION OF RELEVANT ARTICLES. THE PURPOSE OF THE REVIEW IS TO EXPLORE MOTHERS' AND HEALTH VISITORS' PERCEPTIONS AND EXPERIENCES OF PERINATAL MENTAL HEALTHCARE.

The subjectivity inherent in the application of quality criteria coupled with the risk of excluding articles on the basis of a methodological deficit (such as failure to report reflexivity) informed the decision not to use a quality appraisal checklist **(CARROLL & BOOTH, 2015)**. This is especially pertinent when considering articles written by clinicians rather than researchers, who may provide invaluable insight into the views of providers and recipients of interventions, but risk having their findings excluded on the basis of flawed reporting or methodology. Moreover, even when appraisal checklists are used in qualitative evidence syntheses, authors often state that no studies are excluded from the review based on the quality of the methodology **(BUTTON ET AL, 2017; SAMBROOK SMITH ET AL, 2019; STANEVA ET AL, 2015; WATSON ET AL, 2019)**.

6.3. Results

The key features of articles that were identified to provide the starting point for this review are presented in tables 6.1. 6.2. and 6.3 The first table includes systematic reviews, meta-syntheses, meta-ethnographies and integrative reviews (n=17). The second table includes primary studies (n=22). A small number of syntheses and primary studies in these two tables include studies that integrate the views and experience of mothers with HVs or comparable health professionals, but the majority of the studies focus exclusively on mothers. The third table includes studies that are solely focussed on the experience of the views of health professionals, with all these studies including HVs or focussing exclusively on HVs (n=15). A further table, 6.4., includes a summary of the grey literature that was discovered during the course of the investigation (5 surveys).

The themes identified by the authors of the studies are presented alongside some tentative suggestions regarding their implications for health visiting perinatal mental health practice. Although the majority of the 'pearl' articles were published before 2009, the time frame for the analysis has been condensed to 2009 – 2019. This is for two reasons. The first is that the 'pearl' articles were chosen because of their association with the primary LV research and therefore help to provide a 'bridge' between the past, the present and the future. The second reason is that although we can learn from the past, that doesn't necessarily mean that we have to repeat it. Context, people, knowledge and understanding are in a constant state of 'becoming'. As the intention of this thesis is to make some tentative suggestions about what might happen in the future, it makes sense to review studies that are more commensurate with current clinical practice, lifestyles and circumstances. As there is universality in the human condition and experience, reflections on research findings from other countries are included in the discussion where it seems appropriate to do so.

TABLE 6.1: SYSTEMATIC REVIEWS, META-SYNTHESES, META-ETHNOGRAPHIES AND INTEGRATIVE REVIEWS IDENTIFIED DURING THE EVOLVING PROCESS OF A HERMENEUTIC LITERATURE REVIEW, SELECTED FOR THEIR FOCUS ON THE VIEWS AND EXPERIENCES OF MOTHERS IN RECEIPT OF PERINATAL MENTAL HEALTHCARE.

STUDY	YEAR	STUDY DESIGN	MAIN THEMES	IMPLICATIONS FOR HV INTERVENTION
Mollard EK (2014) A qualitative meta-synthesis and theory of postpartum depression. Issues in Mental Health Nursing. 35: 656 – 663 DOI: 10.3109/01612840. 2014.893044	2014	Synthesis of 12 qualitative studies from around the world, based on Noblit and Hare's meta-ethnography. The purpose was to elucidate maternal experiences of postnatal depression. (n = 485 women)	5 themes were identified that reflect the progression of postnatal depression from crushed maternal role expectations, withdrawal, loss of sense of self to intense feelings of vulnerability. All these 4 steps in the process are influenced by practical life concerns.	Interventions should respond to where the mother is in the 4-step process, as well as seeking to ameliorate the practical life concerns she is experiencing. All mothers might benefit from more information about what to expect and support with adapting to the changes.
Megnin-Viggars, O., Symington, I., Howard, L., & Pilling, S. (2015). Experience of care for mental health problems in the antenatal or postnatal period for women in the UK: a systematic review and meta-synthesis of qualitative research. Archives of Women's Mental Health 18(6): 745–759. https://doi.org/10.1007/s00737-015-0548-6	2015	Thematic synthesis of 39 studies of pregnant or postnatal women (up to1 year post-birth) with, or at risk of, developing a mental health problem. Purpose was to identify factors that improve or diminish maternal experience of mental health service provision. (n = 955 women)	Themes: An unmet need for collaborative and integrated care; stigma and fears about loss of custody; healthcare professionals unable or unwilling to address psychological needs; focus on babies over mothers; importance of non-judgemental and compassionate support; an unmet need for information; importance of service user involvement in treatment decisions.	Women's experience of accessing and engaging with care for mental health problems could be improved if given the opportunity to develop trusting relationships with healthcare professionals who acknowledge and reinforce the woman's role in caring for her baby in a non-judgemental and compassionate manner, and foster hope and optimism about treatment. Information for women, their families and healthcare professionals, and the provision of individualised care and treatment, are also crucial to enable full implementation of a person-centred programme of care.

Staneva AA, Bogossian F, Wittkowski A (2015) The experience of psychological distress, depression, and anxiety during pregnancy: A meta-synthesis of qualitative research. Midwifery 31(6): 563–573. https://doi.org/10.1016/j.midw.2015.03.015	2015	8 studies representing the views of women, from 5 countries, regarding their experiences of antenatal psychological distress. (n = 128 women)	Loss of control over the physical and emotional changes (allied to a sense of loss, unrealistic expectations and absence of supportive relationships) associated with pregnancy exacerbated feelings that things were not as they should be. Feeling guilty about negative feelings precipitated avoidant coping strategies and emphasized absence of understanding, caring, non-judgemental, well-informed (and therefore helpful) others and led to feeling overwhelmed, scared, lonely, desperate and self-silencing. With the help of others, mothers developed their own resilience strategies.	Health professionals need to provide more information that will enable mothers to prepare for, and adapt to, the many changes that accompany pregnancy in order to foster a healthy self-image and promote self-care. The importance of social support from partners, friends and families and extended social networks should be emphasized.
Plunkett C, Peters S, Wittkowski A (2016) Mothers' Experiences of Recovery from Postnatal Mental Illness: A Systematic Review of the Qualitative Literature and Metasynthesis.JSM Anxiety Depress 1(4): 1019	2016	14 studies from 8 countries reporting maternal experiences of recovery from puerperal psychosis or postnatal depression. (n=395 women)	4 stages of recovery identified: recognizing the problem; seeking help; achieving recovery; maintaining recovery. Intertwined with these stages were additional themes: crisis and relational distress; getting help to access help; accepting help; sharing with others like me; coping; noticing recovery; incorporating coping strategies into everyday life; acquiring a different model of motherhood; processing the experience.	Information should be given to mothers and significant others about signs and symptoms of common mental health problems so that mothers are more likely to access help before a crisis point is reached. Significant others also need support to ameliorate the distress of not knowing what to do or how to help mothers with mental illnesses. The support from families is a key factor in the recovery process. Mothers acknowledged that they needed to limit their expectations of themselves and set small practical and manageable goals to enhance their sense of coping. Continued use of coping strategies were also identified as essential to maintaining recovery coupled with reduced and more realistic expectations of personal capacity to manage demands of motherhood. Timing of support is important – mothers need to have opportunities to reflect on their experiences with peers and professionals once their symptoms begin to decrease and they feel more in control.

Wittkowski A, Patel S, Fox JR (2017) The experience of postnatal depression in immigrant mothers living in western countries: a meta-synthesis. Clinical Psychology & Psychotherapy. https://doi.org/10.1002/cpp.2010	2017	Metasynthesis of 16 studies exploring the experience of postnatal depression of 337 immigrant women living in Western countries, including the UK.	2 main themes + 7 subthemes: **Migration factors** feeling alone relationships conflict real life worries **Cultural factors** cultural beliefs and values upholding gender roles adhering to childbirth rituals and practices	As mothers were in a foreign country with limited or no access to family and friends and the usual cultural practices associated with childbirth in their own country, the experience of loneliness and lack of practical and social support was more acute. HVs need to be aware of cultural norms, expectations and explanatory models of illness that might affect immigrant mothers' perceptions of illness and services.
Hadfield H, Wittkowski A (2017) Women's experiences of seeking and receiving psychological and psychosocial interventions for postpartum depression: a systematic review and thematic synthesis of the qualitative literature. J Midwifery Women's Health 62 (6): 723-736. http://dx.doi.org/10.1111/jmwh.12669	2017	17 studies from 4 countries exploring women's experiences of professional support for postnatal depression. (n = 585)	4 themes: the process of help-seeking; barriers to seeking and accepting support; valued aspects of support; and outcomes. Mothers experienced difficulties recognizing that something was wrong and were often prompted to access help by friends and family. Negative perceptions of primary care services (under-resourced, fragmented) and limited expectations that they would be helpful (possibly triggered by lack of clarity about professional remit; bad experiences of non-compassionate care and sense of powerlessness) led to self-silencing and delays in seeking help. Variations in perceptions of causes of postnatal depression influence maternal motivation to access treatment eg, some mothers did not agree with the medical model and therefore did not want to take antidepressants. Stigma associated with 'depression' led to feelings of shame and guilt and reluctance to reveal symptoms and access help. Maternal concerns about being seen as 'not coping' or a 'bad mother' also inhibited disclosure. The quality of the relationship with the health professional providing support was a key indicator of maternal engagement.	Mothers wanted anticipatory information not only about common mental health problems but also about aspects of childcare. Mothers valued being able to establish relationships with non-judgemental, genuine, caring, health professionals that fostered continuity, containment, comfort and trust. Women who felt listened to felt validated, more able to 'offload.' order their thoughts and gain a different perspective. Developing skills in problem-solving and other coping strategies was also considered beneficial. Support was considered more beneficial if it was offered by a health professional who was perceived as knowledgeable about both mental health and motherhood. Maternal perceptions of what constituted optimal support included community-based support adapted to individual needs that included practical support. Parenting-based outcomes are important for women with postnatal depression and interventions that include a focus on both self and infant care are likely to be beneficial. Premature termination of interventions led to apprehensiveness about subsequent capacity to cope. Preparing for endings and providing re-inforcing, supportive follow-up sessions might be helpful.

Button S, Thornton A, Lee S, Shakespeare J, Ayers S (2017) Seeking help for perinatal psychological distress: a meta-synthesis of women's experiences. British Journal of General Practice 67 (663): e692-e699. DOI:10.3399/bjgp17X692549	2017	24 UK studies investigating the factors influencing maternal help-seeking for perinatal distress. (total number of women included in the meta-synthesis not provided).	Three main themes: difficulties in disclosing/identifying perinatal MHPs; expectations and previous experiences of health care/support from health professionals; the stigma around having a mental illness/not coping / being seen as a 'bad' mother.	Women should be given clear information about the roles of different health professionals and the range of symptoms that mothers might experience during the perinatal period. Continuity of care is important in order to provide opportunities to build trusting relationships and provide the ambience conducive to disclosing sensitive information. Health professionals need to be sensitive to maternal concerns about not coping or being seen as a 'bad' mother.
Scope A, Booth A, Morrell J, Sutcliffe P, Cantrell A (2017). Perceptions and experiences of interventions to prevent postnatal depression. A systematic review and qualitative evidence synthesis. J Affective Disorders 210: 100 – 110 doi: 10.1016/j.jad.2016.12.017	2017	22 studies involving 982 service users and 43 health care professionals from 7 different countries. The purpose of the review was to provide a service-user and service-provider perspective on the uptake, acceptability and perception of harms of antenatal and postnatal interventions designed to prevent postnatal depression.	Identified themes important in the prevention of PND included support; empowerment; practical implications for service delivery.	Health professionals need to proactively provide information about what to expect during pregnancy, birth and the postnatal period. Flexibility is needed in the dose, format and mode of delivery of interventions. Women appreciated learning practical strategies such as mind-body exercises and learning lullabies. Continuity of care is important with avoidance of sudden /premature endings and provision of follow-up when needed.
Dahl B., Hermansen, M, Severinsson E (2017) Lost in a Nameless Chaos—Women's Experiences of Postpartum Depression: A Meta-Ethnographic Study. Open Journal of Nursing 7: 962-977. https://doi.org/10.4236/ojn.2017.78071	2017	10 studies involving 210 women from 6 countries describing mothers' experiences of postnatal depression.	4 themes: feeling trapped by reality; experiencing a nameless chaos; struggling to find a way out; wanting to be seen as normal but suffering person. Becoming a mother was often not what mothers expected and they described losing control and 'losing themselves'.	Access to social support is vital in facilitating coping with the transition to parenthood and recovery from PND. More information is needed to appraise mothers and their families about common causes and symptoms of MHPs, how mental health is assessed and the support that is available. A range of interventions might be helpful provided by competent practitioners who collaborate with other professionals and organisations to provide care tailored to the needs, preferences and circumstances of mothers.

Hansotte E, Payne SI, Babich SM (2017) Positive postpartum depression screening practices and subsequent mental health treatment for low-income women in Western countries: a systematic literature review. Public health reviews 38 (3) doi:10.1186/s40985-017-0050-y	2017	18 studies involving 75,190 participants exploring factors that influence access to treatment for postpartum depression in low income women.	Cultural, physical and social factors all influenced access to treatment for postnatal depression. Mothers did not always understand the screening process or felt that they could overcome their symptoms without help. Maternal negative perceptions of healthcare providers also influenced their reluctance to reveal their symptoms or access care. Home-based interventions and opportunistic approaches to boost emotional well-being might be beneficial in improving access and outcomes.	HVs need to be aware that low-income mothers, in particular, may have had previous experiences of engagement with health professionals where they have felt 'talked down to' or have had their concerns dismissed. Potential barriers to revealing symptoms or accessing care must be taken into account as well as the multiple factors that precipitate symptom expression, the symptoms experienced and when and how those symptoms are disclosed. Different strategies, including general lifestyle interventions, may be acceptable to different people.
Schmied V, Black E, Naidoo N, Dahlen HG, Liamputtong P (2017) Migrant women's experiences, meanings and ways of dealing with postnatal depression: A meta-ethnographic study. PLoS ONE 12(3): e0172385. https://doi.org/ 10.1371/journal.pone.017238	2017	15 papers reporting findings from 12 studies from 4 countries involving 256 women. The purpose of the synthesis was to report migrant women's experiences of postnatal depression.	4 metaphors describe the themes identified: 'I am alone, worried and angry—this is not me!'; 'Making sense of my feelings' 'Dealing with my feelings' and 'What I need to change the way I feel!'. Women felt a deep sense of loneliness, were worried for themselves and their children and angry about the situation in which they found themselves. It was not acceptable to express feelings of anxiety or depression in some cultures and mothers therefore attributed the way they were feeling to physical causes. Loss of social support and cultural traditions (or conflicting cultural expectations) also exacerbated maternal feelings of isolation and vulnerability. Women didn't know what help was available or how to access it. Communication difficulties compromised access to care.	Health professionals need ongoing training in cultural competence. Communicating effectively is important especially with regard to acknowledging the challenges of talking about mental health problems. Migrant women need to be offered social and practical support as early as possible during pregnancy. Peer support might be helpful.

Fellmeth G, Fazel M, Plugge E (2016) Migration and perinatal mental health in women from low and middle-income countries: a systematic review and meta-analysis. International Journal of Obstetrics and Gynaecology 124(5):742-752.	2017	Forty-five articles reporting on 40 studies with a total of 19,349 (7,895 migrant women and 11,454 women in comparison groups) were included in the final analysis. The purpose was to summarise the causes, prevalence and impact of perinatal disorders in migrant women and to make recommendations about appropriate interventions.	Migrant women are more likely to experience perinatal depression than non-migrant women. Previous trauma, isolation and lack of family and peer support contribute to mental ill-health in migrant mothers. Culturally appropriate assessments and interventions need to be provided for this vulnerable group.	HVs need to be aware of the additional stresses experienced by migrant women especially if they are fleeing from frightening conditions and are isolated from family, friends and peers. Mental health needs should be assessed and addressed as early as possible during pregnancy with special consideration given to helping mothers to access practical, emotional and social support.
Ou CH, Hall WA (2018) Anger in the context of postnatal depression: an integrative review. Birth 45(4): 336 – 346 https://doi.org/10.1111/birt.12356	2018	24 studies involving 3,025 women exploring the expression of maternal anger in the context of postnatal depression.	Anger is often experienced alongside postnatal depression. There is a relationship between anger, feeling powerless in relationships and circumstances, and depression. Anger may be related to other emotions such as guilt, shame and disappointment. Anger and depression are associated with the mismatch between reality and expectation and the availability of support. Maternal anger can influence emotional availability to children, partners and others and predispose to expressions of dissatisfaction (with self and others) and aggression.	HVs and other professionals need to be aware that anger can be comorbid with depression and may be manifest as frustration, emotional lability or hostility. This, in turn, may make it difficult for mothers to accept and engage with treatment and for clinicians to persist when encountering antipathy or animosity. Maternal anger may also undermine relationships with partners and children who may be on the receiving end of expressions of anger, thereby constituting a potential safeguarding issue.

Sambrook Smith M, Lawrence V, Sadler E, et al (2019). Barriers to accessing mental health services for women with perinatal mental illness: systematic review and meta-synthesis of qualitative studies in the UK. BMJ Open 9:e024803. doi: 10.1136/bmjopen-2018-024803	2019	35 papers reporting on 32 UK studies to examine service-users and service-providers perceptions of barriers to accessing perinatal mental health services. (total number of women include in the meta-synthesis not provided).	Main themes: there is a lack of knowledge amongst mothers, fathers and health care professionals about signs and symptoms of perinatal mental illness and the roles and responsibilities of different professionals contributing to the pathway of care; mothers experience stigma, guilt and shame about having a mental illness; health care professionals may be reluctant to diagnose / label mental illness; limited staff, time and resources compromise capacity to provide sensitive and responsive care; fragmented, dislocated services hinder inter-professional communication and foster abdication of responsibility for the provision of care; lack of understanding of cultural influences on attitudes to disclosure and treatment; professional distrust in, and inconsistent use of, assessment tools; maternal views about the process of assessment (positive and negative).	Need clarification and shared understanding of roles and responsibilities of different professionals. Health professionals need access to regular and comprehensive training about identifying and managing perinatal mental health problems. Health professionals need to raise awareness amongst parents about common MHPs – what to look out for and sources of help that are available. Organisations need to increase capacity in primary care services so that health professionals have the time to conduct sensitive, comprehensive assessments and ensure that parents receive timely and culturally appropriate care.
Watson H, Harrop D, Walton E, Young A, Soltani H (2019) A systematic review of ethnic minority women's experiences of perinatal mental health conditions and services in Europe. PLoS ONE 14(1): e0210587. https://doi.org/10.1371/journal.pone.0210587	2019	15 studies from the UK, involving 4,970 participants, exploring ethnic minority women's experiences of perinatal mental illness and care.	7 overarching themes identified: awareness and beliefs about mental ill-health; influence of culture; symptoms and coping strategies; isolation and seeking support; accessing mental health services; experiences of mental health services; what women want. Symptoms described include anxiety; low mood; prolonged crying; pain in the chest and stomach, difficulty leaving the house; appetite and sleep problems.	Health professionals need training in culturally sensitive and competent care. Mothers, fathers, families and friends need culturally appropriate information written in the right language or communicated in culturally sensitive ways about perinatal MHPs and sources of support. Mothers need to have the opportunity to build relationships with compassionate, non-judgemental healthcare providers so that they feel comfortable disclosing symptoms and are more likely to engage in treatment tailored to their preferences and needs. Services need to be organized so they are less fragmented.

Newman TC, Hirst J, Darwin Z (2019) What enables or prevents women with depressive symptoms seeking help in the postnatal period? British Journal of Midwifery 27 (4): 219- 227	2019	4 studies from 3 countries involving 118 women to identify the factors influencing help-seeking in women with postnatal depressive symptoms.	Themes: recognition of symptoms; the reactions of others; the organisation of services. Services were not necessarily geared to assess mental as well as physical health. Mental health services were not well publicised or connected and it was difficult to know how to gain access to them or to gain access because of high referral thresholds and long waiting lists. Delivery settings were often unappealing and not welcoming. Attitudes and behavior of health professionals also influenced maternal inclination to disclose symptoms.	Mothers and their families need more information about the range of mental health problems that mothers might experience, how and when to seek help, and the professionals and services available to help manage mental health problems. One meaningful and memorable conversation with a caring health professional can facilitate disclosure and help-seeking. Balance needed between normalizing symptoms and acknowledging distress by both mothers, significant others and health professionals.Family-centred care is needed to ensure that the needs of all family members are considered and met.
Holopainen A, Hakulinen T (2018) New parents' experiences of postpartum depression: a systematic review of qualitative evidence. JBI Database of Systematic Reviews and Implementation Reports 17(9): 1731 – 1769 doi: 10.11124/ JBISRIR-2017-003909	2019	13 studies involving 199 mothers and 2 studies involving 20 fathers provided information on parental experiences of depression experienced in the first postpartum year.	Themes: Low resilience in mothers contribute to feelings of loss of control; ambivalent feelings experienced by mothers cause suffering and distress; lack of support from health professionals and significant others contribute to maternal feelings of anger and despair; a sense of hopelessness and helplessness arise from maternal perceptions of inability to manage financial worries and the demands of motherhood. Fathers experience disappointment from the lack of support from partners and significant others and a lack of resilience contributes to their sense of loss of control.	This qualitative evidence synthesis provides further evidence of the themes emerging from previous studies. HVs need to explore the many factors that might contribute to psychological distress and the many symptoms that might be manifestations of that distress, including anger, frustration, disappointment, despair. This must include consideration of the relationship between maternal expectations and reality, perceptions of significant relationships and sources of available support.

TABLE 6.2. PRIMARY STUDIES IDENTIFIED DURING THE EVOLVING PROCESS OF A HERMENEUTIC LITERATURE REVIEW, SELECTED FOR THEIR FOCUS ON THE VIEWS AND EXPERIENCES OF MOTHERS. OR MOTHERS AND HEALTH PROFESSIONALS, IN RECEIPT OF, OR PROVIDING, PERINATAL MENTAL HEALTHCARE.

STUDY	YEAR	STUDY DESIGN AND LOCATION	MAIN THEMES	IMPLICATIONS FOR HV INTERVENTION
Raymond JE (2009) 'Creating a safety net': Women's experiences of antenatal depression and their identification of helpful community support and services during pregnancy. Midwifery 25. http://dx.doi.org/10.1016/j.midw.2007.01.005	2009	Semi-structured interviews with 9 women, with babies between 6 weeks and 12 months old, who had experienced at least 2 weeks of feeling low during pregnancy. The purpose of the study was to explore maternal experiences of antenatal depression and the support they found helpful. Location: England	Themes: Loneliness and emotional isolation. Some mothers had very limited social networks; other mothers had family and friends to support them but still felt emotionally isolated. Extremes of lack of support were manifest as conflict. The fear of abandonment and the need to be sensitive to partners' needs and moods was emotionally tiring for some mothers. 'Self-silencing' of maternal needs and feelings was a common phenomenon. Mothers lamented the absence of continuity of care that compromised their inclination to share their feelings and, in some circumstances, meant that their symptoms deteriorated. Health professionals appeared rushed and busy that made mothers feel discouraged or that their symptoms were minimized. The focus on the well-being of the baby to the exclusion of enquiries about the mother's mental health made mothers feel like a 'walking womb' or a 'baby carrier'. Opportunities to connect with other women with similar experiences was found to be helpful and described as a 'safety net'.	All health professionals need to be aware that there may be many reasons why mothers find it difficult to share how they are feeling so should make every effort to create environments conducive to disclosure (that includes having time to listen, expressing genuine interest in emotional well-being and providing continuity of care). Helping mothers to access a range of sources of support that enables them to share their experiences with peers is considered helpful.
Furber CM, Garrod D, Maloney E, Lovell K, McGowan L (2009) A qualitative study of mild to moderate psychological distress during pregnancy. Int J Nurs Stud 46: 669-677 10.1016/j.ijnurstu.2008.12.003	2009	Semi-structured interviews with 24 pregnant women to explore the experiences of mild to moderate psychological distress. Location: England	Women reported a number of factors that predisposed to antenatal psychological distress including adverse life events such as bereavement or being sexually abused as a child or previous birth trauma or fetal loss. More immediate triggers that precipitated symptoms were problems with the current pregnancy. The distress impacted on many aspects of mothers' lives including work, intimate partner relationships and social networks. Coping strategies included 'time for self', 'prioritising', learning to say 'no' and seeking out information and self-help strategies. Unhelpful coping strategies include obsessive cleaning, accessing too much information and not leaving the safe environment of the home.	Sensitive inquiry about the causes and nature of distress is needed so that appropriate management strategies can be devised. Primary care professionals need appropriate training on how to help women experiencing psychological distress who do not meet the threshold for specialist services.

Chew-Graham CA, Sharp D, Chamberlain E, Folkes L, Turner KM (2009) Disclosure of symptoms of postnatal depression, the perspectives of health professionals and women: a qualitative study. BMC Family Practice 10(7): doi:10.1186/1471-2296-10-7	2009	In-depth interviews with 28 women, 19 GPs and 14 HVs participating in a RCT of antidepressants versus HV delivered LVs for treatment of postnatal depression. Location: England	Women attributed their postnatal depression to psychosocial causes such as stresses of parenthood, changing relationships, reality not meeting expectations and distressing memories from the past triggered by the birth. Others thought that symptoms were caused by hormonal upheaval or response to stress. Most women thought that the GP and HV didn't have much to offer in the way of help apart from anti-depressants. Health professionals also had different views about the aetiology of PND. General agreement that cause of PND was multifactorial. GPs and HVs often relied on professional intuition to detect it. Some HVs asserted that they were not appropriately trained to diagnose PND and some GPs didn't like to use the label PND. Mothers were inhibited from disclosing how they felt by perceptions of health professionals as not being willing to listen, not knowing that assessing maternal mental health was part of their role, not knowing what treatments were available, not wanting anti-depressants, or were concerned about what might happen if they did share how they were feeling. Many mothers did not anticipate that either the GP or the HV would be able to help them. Some HVs thought it was not ethical to ask women how they were feeling if the only treatment option available was antidepressants. Corporate working meant that HVs were less likely to see the same mother on successive occasions and therefore less likely to develop a trusting relationship conducive to disclosure of sensitive issues.	HVs need to be aware of maternal perceptions of causes of PND and the reasons why mothers might find it difficult to disclose how they are feeling. HVs also need to be aware of their own perceptions and attitudes that might influence whether and how they enquire about maternal emotional well-being. It may be that the reticence of HVs to ask about emotional well-being or to diagnose PND makes them appear less capable / confident to mothers. In order for mothers to disclose how they are feeling HVs and other professionals need to indicate that maternal mental health is part of their professional remit. Both mothers and health professionals need to know the range of support options that are available apart from anti-depressants.
Turner KM, Chew-Graham C, Folkes L, Sharp D (2010) Women's experiences of health visitor delivered listening visits as a treatment for postnatal depression: A qualitative study. Patient Education and Counselling. 78: 234 - 239	2010	In-depth interviews with 22 women who had received 4-8 weekly, hour-long, listening visits from specially trained health visitors participating in a research study. The purpose of the study was to find out what mothers thought about listening visits. Location: England	Once mothers had established a relationship with their research HV they found her easy to talk to. Conversely, even though some women said they liked their practice HV they didn't feel comfortable talking about sensitive issues with her. They thought the HV might share this information with other mothers and they were more careful about what they shared with their practice HV because they didn't want to be seen as a bad mother. Some mothers said their HVs were too critical or brisk in their approach. Mothers who had underlying issues or exacerbations of pre-existing depression found that 8 listening visits was not enough and some felt angry when the treatment ended.	Women offered listening visits should be informed about the format the therapy will take. HVs should discuss issues around confidentiality at the first visit and professional responsibilities towards the mother and child. Women may wish to access other forms of support before, during or after receiving listening visits.

Slade P, Morrell CJ, Rigby A, Ricci K, Spittlehouse J, Brugha TS (2010) Postnatal women's experiences of management of depressive symptoms: a qualitative study. The British Journal of General Practice 60(580): e440–e448. doi:10.3399/bjgp10X532611	2010	Semi-structured interviews with 30 women who scored 18+ on the EPDS at 6 weeks postpartum exploring their experiences of perinatal mental health care provided by HVs participating in the PoNDER trial. Location: England	Themes; difficulty recognizing symptoms and seeking help; perceptions of health visitor's role and willingness to listen; experiences of support provided by HVs in both the interventions and control groups.	40% of women in the intervention groups who were eligible for support declined the offer of a HV intervention. HVs therefore need to provide clear information about their role and area of expertise and what mothers can expect from the support offered by HVs. HVs also need to be aware that it is difficult for some mothers to share how they feel and/or admit that they are not coping so they may present with indirect reasons for initial contact such as concerns about the baby. Mothers who did receive the HV intervention found it helpful.
Almond P, Lathlean J (2011) Inequity in provision of and access to health visiting postnatal depression services. Journal of Advanced Nursing 67(11): 2350–2362. doi: 10.1111/j.1365-2648.2011.05669.x	2011	Case study involving 21 observations of HVs visiting postnatal women, interviews with 20 HVs, 6 managers, 12 English women, 9 Bangladeshi women and 3 other personnel. Location: England	HVs were not necessarily aware of local policy and protocols regarding the assessment and management of postnatal depression. Difficulties in providing an equitable service were raised in that in order to achieve the same level of contact and outcomes, ethnic minority families might need more HV time and additional/different resources. Concerns were also expressed by HVs about how to respond in a culturally sensitive way to ethnic minority mothers a) because they were not sure what was culturally appropriate and b) because they had to rely on interpreters or family members to do the interpretation and there were mixed views as to whether this enabled mothers to share their feelings.	Organisations employing HVs need to have clear policies and protocols specifying what HVs are expected to do and ensure that all HVs know about them and have had appropriate training in culturally sensitive perinatal assessment and care.
Wittkowski A, Zumla A , Glendenning S, Fox JRE (2011) The experience of postnatal depression in South Asian mothers living in Great Britain: a qualitative study, Journal of Reproductive and Infant Psychology 29 (5): 480-492, DOI: 10.1080/02646838.2011.639014	2011	Semi-structured interviews with 10 South Asian mothers to explore their experiences of postnatal depression. Location: Manchester, England	Mothers experienced a 'transitional culture shock' moving from the familiar and enjoyed lifestyle in South Asia to an arranged marriage in a strange environment without support from family and friends. Religious beliefs and family expectations predispose, precipitate or perpetuate distress. In some languages there was not a word for depression and the symptoms mothers felt were described in a variety of ways. Families could be sources of additional distress or support. There was a lack of awareness of the range of support services that were available and a perception that health services discriminated against ethnic minorities.	HVs need to be aware that assessment tools such as the EPDS may not be culturally appropriate for mothers from ethnic minorities who experience or describe postnatal depression in a different way and therefore would not be identified by these tools. HVs and other professionals responsible for the provision of care to ethnic minority women should receive training on the customs, rituals, preferences and expectations of healthcare of mothers from different cultural backgrounds. This includes understanding of family relationships and dynamics that may aggravate the sense of isolation and lack of support.

Patel S, Wittkowski A, Fox JRE, Wieck A (2013). An exploration of illness beliefs in mothers with postnatal depression. Midwifery 29(6): 682–689. https://doi.org/10.1016/j.midw.2012.06.012	2013	Qualitative face-to-face interviews with women who scored 10+ on the EPDS up to 24 months postpartum. Location: Manchester, England. (n = 11 women)	Illness beliefs in PND. Six categories identified: unmet expectations; identifying stressors in their life context; conflict over label; antidepressants: the lesser of two evils; loss of time; uncertain futures. Emotions experienced included low mood, anxiety, anger, a sense of 'lost time' and guilt at not meeting their idealized expectations of motherhood. This led to reduced self-efficacy and self-esteem. Maternal attributions of causes of PND included genetic predisposition; child maltreatment; traumatic pregnancies and births; underlying personality; hormonal changes; biological changes in the brain; difficulties in adjusting to parenthood; changes in lifestyle, weight gain; lack of social support; relationship problems; financial concerns; and work-based worries. Ambivalence was evident about the benefits and stigma associated with labeling their experience as PND; the advantages and disadvantages of taking antidepressants and concerns about the future.	Mothers might benefit from the provision of more information during pregnancy about what to expect with regard to the physical and emotional transition to parenthood. Early postnatal support should focus on normalizing early experiences and helping mothers to acknowledge, ameliorate, or adapt to, the challenges experienced as a result of lifestyle changes, sense of loss and altered relationships.
Henderson J, Redshaw M (2013) Anxiety in the perinatal period: antenatal and postnatal influences and women's experience of care. Journal of Reproductive and Infant Psychology 31(5): 465-478, DOI: 10.1080/02646838.2013.835037	2013	Secondary analysis of data collected at 3 months postpartum from 5332 mothers participating in a 2010 new mothers study. The purpose of the study was to examine the characteristics and experiences of mothers with perinatal anxiety. Location: England	13.9% of women reported antenatal anxiety and 5-20% reported postnatal anxiety with peak prevalence noted at 10 days postpartum by primiparous mothers (compared with 1 month and 3 months postpartum). Less than half the mothers who self-reported anxiety revealed how they were feeling to a health professional. Anxiety was frequently co-morbid with depression. Antenatal anxiety was more common in young and/or single parents, when the pregnancy was unplanned and/or unwanted; when there was a longstanding physical or mental health problem; when mothers were from non-white backgrounds and if they experienced socioeconomic hardship. Women with antenatal anxiety were more likely to be admitted to hospital during pregnancy and more likely to report negative interactions with health professionals including an absence of respect or kindness. At least 75% of mothers who experienced antenatal anxiety did not experience postnatal anxiety or depression. Factors significantly associated with postnatal anxiety were staff communication, respect and kindness; overall satisfaction with care; infant feeding, help after birth and well-being.	HVs need to be aware of the factors that predispose to perinatal anxiety, especially antenatal anxiety, and to appreciate that the majority of mothers do not share how they feel with a health professional. Sensitive enquiry is therefore needed as well as offering strategies that might help to lessen the number and severity of the symptoms mothers are experiencing. As anxiety and depression are so often co-morbid with each other this would include exploring what the additional symptoms are and how they might be alleviated.
McLellan J, Laidlaw A (2013). Perceptions of postnatal care: factors associated with primiparous mothers perceptions of postnatal communication and care. BMC pregnancy and childbirth, 13, 227. doi:10.1186/1471-2393-13-227	2013	Cross-sectional survey of 71 first-time mothers who had given birth in the UK within the preceding 12 months. The purpose of the study was to explore	Satisfaction with communication from health professionals was associated with satisfaction with postnatal care. Ratings of communication with HVs and total satisfaction with postnatal care were significantly related to maternal depression.	HVs need to be aware of how they communicate their understanding of the perceptions and needs of mothers experiencing psychological distress.

Coates R, Ayers S, de Visser R (2014) Women's experiences of postnatal distress: a qualitative study. BMC Pregnancy and Childbirth 14: 359 http://www.biomedcentral.com/1471-2393/14/359	2014	Semi-structured interviews with 17 women who experienced psychological problems in the first postnatal year. Location: England	4 themes emerged: living with an unwelcome beginning; relationships in the healthcare system; the shock of the new; meeting new support needs. Some mothers experienced a feeling of remoteness as a result of negative birth experiences and a sense of disconnection from themselves and their baby as if they were on the outside looking in. Guilt was often expressed in relation to the feeling that their body had let them down and feelings of distress were associated with not knowing what really happened. If mothers felt out of control during the birth they often saw breastfeeding as a means of gaining control and were doubly disappointed if they experienced breastfeeding problems. Most women spoke of feeling uncared for by health professionals; they were not listened to, not asked how they were feeling and not treated as equals in decision-making. Mothers felt overwhelmed with the responsibility of having to look after the baby and the benefits of meeting with other mothers with similar experiences or just getting out of the house every day were highlighted.	Mothers who have negative birth experiences want an opportunity to talk about them. HVs and other health professionals need to be aware of the atypical symptoms that mothers might experience as a result of their sense of disappointment and guilt because the birth didn't go the way they wanted it to. All health professionals, regardless of how busy they are need to be aware of how they come across to the mothers they are supporting as the majority of mothers did not feel cared for by the 'caring professions'. Mothers also need help with coping with the many demands of looking after a new baby especially breastfeeding as this represents an activity over which they can regain a sense of control if it goes right.
Gardner PL, Bunton P, Edge D, Wittkowski A (2014) The experience of postnatal depression in West African mothers living in the United Kingdom: A qualitative study. Midwifery 30:756 – 763 http://dx.doi.org/10.1016/j.midw.2013.08.001	2014	Semi-structured interviews with 6 West African postnatal mothers experiencing low mood. Location: Manchester, England	Symptoms experienced include irritability, struggling to cope, feeling overwhelmed, crying, thoughts of self-harm, feeling tense, under pressure, feeling disconnected. Described their experience as 'stress' or 'distress' rather than depression. Mothers felt that the causes of postnatal depression and the way it was manifested was culture and context specific. In England it was to do with social isolation and lack of practical, emotional and professional support. In West Africa it was to do with failure to produce a male heir, worries about the baby's health, or financial worries. Other themes emerging were loss of sense of self; distrust in others; stigma. Faith was an important protective factor as were their relationships with their baby and with others.	HVs need to be aware of the different perceptions and descriptions of emotional distress used by women from different cultural backgrounds. Mothers also need to be given clear information about the support that they can expect from different professionals and who will share information with whom. Awareness of usual perinatal care in the mother's country of origin is also important. For example, it was suggested that there is a strong sense of community support for mothers in West African communities so enabling access to community groups might be appropriate.

Coates R, de Visser R, Ayers S (2015) Not identifying with postnatal depression: A qualitative study of womens postnatal symptoms of distress and need for support. Journal of Psychosomatic Obstetrics and Gynecology 36(3): 114-121. doi: 10.3109/0167482X.2015.1059418	2015	Semi-structured interviews with 17 women who experienced psychological problems in the first postnatal year. Location: England	Most frequently reported symptoms were tearfulness and anxiety. Other symptoms included frustration; stress; anger; panicky, worried; scared; feeling isolated and lonely; flashbacks and nightmares and intrusive thoughts of suicide. Mothers did not identify with a diagnosis of depression and felt that once health professionals had ruled out depression they were not interested in any other symptoms OR health professionals would suggest that they were depressed when the mothers didn't think that was what they were experiencing. Mothers wanted support even though they did not meet diagnostic criteria because they still felt that the way they were feeling affected their daily functioning and their relationship with their baby. Timing of assessment and support was also considered important. There was a suggestion that an honest respectful chat might be more useful in ascertaining how mothers are really feeling rather than a tick box exercise using a questionnaire that didn't seem to ask the most relevant questions.	HVs need to be aware that maternal experiences of psychological distress can be manifest in different ways and sensitive inquiry should include questions about frustration, stress and anger. The purpose of asking questions about distress is also to determine impact on daily functioning and relationships with others so these considerations should be included in assessment protocols.
O'Mahen HA, Grieve H, Jones J, McGinley J, Woodford J, Wilkinson EL (2015) Women's experiences of factors affecting treatment engagement and adherence in internet delivered behavioural activation for postnatal depression. Internet Interventions 2(1): 84–90. doi:10.1016/j.invent.2014.11.003	2015	17 mothers within 12 months of completing an on-line intervention for postnatal depression completed semi-structured telephone interviews. The purpose of the study was to elicit preferred content for an internet intervention and factors affecting adherence. Location: online	Mothers wanted content that was relevant to their lifestyle and specifically requested information around parenting, relationships and sleep. Some mothers were disappointed at the mismatch between their expectations and reality and felt inadequate and guilty when they compared themselves to other mothers. Some mothers did not bond immediately with their babies or felt deskilled because their babies were difficult to manage and were surprised or confused by their feelings. Although the flexibility of an online intervention fitted in with the demands of motherhood, some mothers expressed a need to have something with a more consistent routine as there were times when they lacked motivation to engage with the programme. Also the demands of motherhood sometimes meant that it was not possible to complete weekly tasks adding to feelings of hopelessness. Worries about stigma and what others might think of them inhibited engagement in some of the tasks as they involved seeking social contact which mothers often eschewed. Failure to engage with the programme confirmed mothers' perceived inability to change and sense of hopelessness. Maternal perceptions of the causes of their symptoms and experiences of other treatments/services influenced their perceptions that the treatment might work. Being let down by other services led to low self-worth and low expectations that anything would help, decreased motivation and greater likelihood of disengaging with treatment. Lack of support from professionals was often compounded by lack of support from family and friends. Mothers wanted more interactive and personalized sessions and ongoing support from someone whom they could talk to about treatment content, task completion and progress.	HVs need to explore maternal perceptions of the causes of their distress and identify predisposing and precipitating factors in order to devise strategies relevant to maternal circumstances. It may also be useful to ascertain past and present levels of, and satisfaction with, contact with other services. The provision of reliable and consistent support also seems to be important.

Hannan J (2016) Older mothers' experiences of postnatal depression British Journal of Midwifery 24(1)	2017	Semi-structured interviews with 4 primiparous women aged 30 yrs+, who had given birth to a child within the last 5 years, to explore their experiences of PND during the first 4 postnatal weeks. Location: UK	Themes: Striving to be a perfect mother; feeling a failure; being sucked dry; shame of the others gaze; feeling stuck and overwhelmed; becoming lost. Mothers who were used to being capable and efficient in their professional lives found it difficult to comprehend that they weren't coping and didn't want to be seen by others as not coping. Mothers who didn't want to burden their loved ones with how they were feeling, avoided social and emotional contact with family and health professionals.	Mothers in this study specifically mentioned the benefits of talking to a counsellor as they did not have the additional worry of feeling responsible for increasing the burden on family members. HVs could provide this independent, non-judgemental support. As older mothers in this study did not exhibit any of the vulnerability factors normally associated with PND, it is important for all professionals to realize that any mother may develop PND. Mothers who have stable intimate partner relationships, supportive families and social networks may still not be able to activate the emotional support they need.
Evans K, Morrell CJ, Spiby H (2017) Women's views on anxiety in pregnancy and the use of anxiety instruments: a qualitative study. J Reprod Infant Psychol. 35: 77-90.	2017	Focus groups with 19 women who had given birth within the last 9 months to explore their views of anxiety during pregnancy and the use of anxiety assessment tools. Location: England	Mothers believed that feeling anxious was abnormal and therefore found it difficult to share feelings of anxiety with family and health professionals and this led to feelings of social isolation. Mothers valued opportunities provided by peer support to validate and normalize how they felt. Symptoms were aggravated by health professionals who dismissed or minimized the importance of symptoms. Mothers were frustrated by having to repeatedly explain symptoms to different professionals. Not all questions on assessment tools were considered helpful or appropriate although they were considered useful if they triggered more in-depth exploration of symptoms and access to support. Mothers also worried about the implications of a statement about their mental health on their medical records The most acceptable questionnaire was the Pregnancy specific Anxiety Questionnaire (PRAQ-R). Mothers did not see the relevance of being asked questions if the questions did not appear to be valued by the assessor.	Mothers want the opportunity to discuss their anxiety but will only respond truthfully about their mental health if they believe that the person asking the questions is open to an exploration of their answers and can signpost them to appropriate support.
Franks WL, Crozier KE, Penhale BL (2017) Women's mental health during pregnancy: A participatory qualitative study. Women and Birth 30(4): 179-187. http://dx.doi.org/10.1016/j.wombi.2016.11.007	2017	17 mothers and 15 health professionals participated in individual or group interviews to explore perceptions of the factors that undermine maternal mental health during pregnancy. Location: England	Six categories of influences on antenatal maternal mental health identified: individual factors; personal experiences; pregnancy related factors; relationship factors; social conditions; and material conditions.	Maternal mental health is influenced by multiple factors that need to be taken into account during the course of comprehensive, holistic assessment to ensure that interventions are appropriate. As well as individual biological predisposition, personality and current stressors, consideration must be given to the contribution of socioeconomic circumstances and relationships with parents, partners and peers.

Peeler S, Stedmon J, Cheung Chung M, Skirton H (2018) Women's experiences of living with postnatal PTSD. Midwifery 56: 70-78 http://dx.doi.org/10.1016/j.midw.2017.09.019	2018	Semi-structured interviews were used to explore the views of 7 women who were 6 weeks postpartum and experiencing symptoms of PTSD. Location: England	Mothers who had underlying issues such as past trauma, back problems, pelvic girdle pain, relationship issues, financial difficulties seemed to be at increased risk of PTSD especially if underlying conditions were not taken into account by the midwife in charge of their care during labour and postnatally. Women reacted in different ways to traumatic birth – some wanted to find out what had happened, to see their notes and to talk about their experience. Others wanted to bury the memories and forget about the experience. Availability of partner, family or friends seemed to affect maternal ability to process the experience. It was suggested that women with alexythimia (inability to describe, process or express emotions) might be more prone to develop PTSD because of their inability to communicate how they felt.	Although formal de-briefing is not recommended for women who have experienced a traumatic birth, an 'afterthoughts' service seems to be beneficial where mothers are given the opportunity to go through their notes with a midwife. Health professionals need to be aware of underlying factors that might increase the likelihood of mothers experiencing a birth as traumatic. The attitude and behavior of midwives during labour seems to matter in terms of how the experience is remembered.
Henderson J, Jomeen J, Redshaw M (2018). Care and self-reported outcomes of care experienced by women with mental health problems in pregnancy: Findings from a national survey. Midwifery 56: 171–178. doi:10.1016/j.midw.2017.10.020	2018	A survey of a random sample of women who had a live birth in Jan 2014 were sent a questionnaire when their infant was 12 weeks old. 4578 women self-identifying with MHPs during pregnancy provided information on their experiences of care. Location: England	Women who were less than 30 yrs of age, multiparous, living in deprived or difficult circumstances, from an ethnic minority, with learning disabilities, long standing MHPs or pregnancy related health problems were more likely to report an antenatal MHP. At 1 month postpartum, women who had experienced antenatal MHPs were more likely to experience anxiety or depression. All aspects of mental health were significantly poorer in these women at 3 months postpartum and they felt less bonded with their baby than those women without antenatal MHPs. They also used fewer positive adjectives in descriptions of their baby and were twice as likely to report that their babies were more difficult than average. Women who received support or advice for their MHP during pregnancy reported fewer difficulties with the relationship with their baby. Women with antenatal MHPs, despite receiving more support were more likely to report dissatisfaction with the way they were treated by health professionals.	HVs need to be aware of the factors contributing to an increased vulnerability to antenatal MHPs as well as the relationship between antenatal and postnatal MHPs and the impact of the MHPs on maternal perceptions of their relationship with their baby. The importance of 'listening' to mothers and treating them with kindness and respect is emphasized. Maternal attributions about their baby might also provide an indication of the mental state of the mother.

Lever Taylor B, Billings J, Morant N, Bick D, Johnson S (2019) Experiences of how services supporting women with perinatal mental health difficulties work with their families: a qualitative study in England. BMJ Open. 9:e030208. doi:10.1136/bmjopen-2019-030208	2019	Semi- structured interviews with 52 women who had received help for a MHP and 32 partners/ family members. Location: England	Mothers participating in the study had accessed a range of different services to help manage their mental health problems. 12/52 (23%) had accessed specialist health visitor or midwifery services. Three main themes: the centrality of women's families; experiences of partners and families feeling excluded by services; ambivalence among women and family members about increasing family involvement/support.	Mothers, their partners and other family members may not always have similar views about the extent of involvement that partners/family members should have in appointments and decisions about the care that mothers with MHPs received. Whilst there was criticism of the tendency of health professionals to exclude partners/family members from care plans there was also a sense (from the mothers) that this might not always be appropriate. Partners and other members of the family also felt that mothers, because of their mental illness, might not feel able to include their family members for various reasons, including a cultural expectation that the mothers should be able to cope. It requires great sensitivity and skill to know how and when to involve partners / other family members.
Hore B, Smith DM, Wittkowski A (2019) Women's experiences of anxiety during pregnancy: an interpretative phenomenological analysis. J Psychiatry Behav Sci 2(1): 1026.	2019	Semi-structured interviews with 7 pregnant women to explore women's experiences of anxiety during pregnancy. Location: England	Maternal worries and anxieties centred on the uncontrollability and uncertainty of changes that were happening to their body and lifestyle as a result of becoming pregnant, worries about how they were going to manage during pregnancy, labour and after the baby was born and fears about losing the baby or something being wrong with the baby. Women described feeling overwhelmed, panicky, out of control, overthinking, frantic. Being pregnant interfered with usual coping strategies such as drinking or exercising. Social support was found to be helpful in ameliorating symptoms. Some experienced a sense of powerlessness, anxiety and loss of hope (of providing their baby with the best start) in the face of pregnancy complications. When reality did not match expectations, mothers felt sadness and concern. Comparisons with other pregnant mothers and perceived social pressure to think, feel and act in certain ways led to feelings of guilt and shame and a sense that they were abnormal. Frustration and dejection was experienced with regard to the inadequacies of the healthcare system characterized by depersonalized care, a tick box approach to assessment and fear of being judged. One mothers said it would be good to know why questions were being asked and what was going to happen to the answers. Compassionate responses from health care professionals were also noted especially in helping to dispel myths and normalize experiences. Mothers felt that having a relationship with just one midwife helped to build trusting relationship, gave mothers a sense of control and reassurance and made it easier to share worries and concerns.	Mothers felt that they would feel less anxious and more able to cope with uncertainty and unpredictable events if they had continuity of care from one MW and if they were given information and explanations about what had happened or what was going to happen. Curious, open-minded enquiries are preferable to tick box assessments. Compassionate, collaborative care can really make a difference to how mothers feel and their capacity to cope. Signposting women to appropriate peer support groups was also considered beneficial.

Das R (Ed) (2019) Migrant mothers' mental health communication in the perinatal period. Guildford, University of Surrey. http://epubs.surrey.ac.uk/852845/1/Migrant%20Mothers%27%20Perinatal%20Mental%20Health%20Communication.pdf	2019	Semi-structured interviews with 68 migrant women recruited via social media or door-to-door invitation and determination of eligibility by a recruitment agency. The purpose of the report was to explore perinatal mental health difficulties amongst migrant mothers. Location: England	Awareness of the negative perceptions of others of MHPs meant that it was difficult for women to share how they were feeling. Loneliness and social isolation were common experiences. Several factors relating to the circumstances of migration such as culture, tradition, taboos, proximity of in-laws, arranged marriages, unsupportive partners contributed to distress. Mothers appreciated the opportunities to find out from other mothers, the internet and health professionals about common perinatal MHPs and to share how they were feeling. Immediate family were not always sympathetic or helpful. Concern was expressed about taking anti-depressants and potential involvement of social services. Nurses and midwives represented the most trusted group of HCPs although it was observed that the significant amount of time spent on record-keeping limited the time available for talking. Superficial assessments of mental health, limited empathic understanding and preferential focus on the baby made mothers feel that their own well-being was neglected. Continuity of care was appreciated.	HVs need to be aware of the many factors that influence the mental health of migrant mothers, the difficulties they might experience in sharing how they feel and their need for information and support. HVs need to take advantage of the perception that nurses and midwives are the most trusted group of health professionals by letting mothers know that they do care about their emotional well-being and by providing sensitive comprehensive assessments that are not dominated by record-keeping.

TABLE 6.3. PRIMARY STUDIES IDENTIFIED DURING THE EVOLVING PROCESS OF A HERMENEUTIC LITERATURE REVIEW, SELECTED FOR THEIR PRIMARY FOCUS ON THE VIEWS AND EXPERIENCES OF HEALTH PROFESSIONALS PROVIDING PERINATAL MENTAL HEALTHCARE.

STUDY	YEAR	STUDY DESIGN AND LOCATION	MAIN THEMES	IMPLICATIONS FOR HV INTERVENTION
Edge D (2010) Falling through the net - Black and minority ethnic women and perinatal mental healthcare: health professionals' views. Gen Hosp Psychiatry 32: 17-25 http://dx.doi.org/10.1016/j.genhosppsych.2009.07.007	2010	Semi-structured interviews and focus groups involving 42 health professionals (5 HVs) to explore provision of perinatal mental healthcare for black and minority ethnic women.	Mixed views about the utility of existing screening tools meant that they were not always used. Health professionals relied on professional intuition but also felt they lacked competence and confidence in identifying perinatal MHPs for BME women but also more generally for all women. Even those who had received specialist training felt that they lacked the requisite knowledge and skills to enable adequate identification and management of women with MHPs. Pressure on services meant that only mothers with severe mental illness were prioritised. MWs and HVs felt that their lack of training/knowledge disadvantaged them in the eyes of other health professionals who did not accept their assessments of maternal mental state. Lack of timely access to appropriate care was highlighted as was the lack of opportunities for collaboration particularly as a result of HVs being moved out of GP premises into central, often non-NHS locations. Absence of multiagency collaboration also generated lack of awareness/ confidence in the competence of other professionals. Pressure on HV workloads compromised capacity to build relationships with other professionals and mothers. Although there was an acknowledgement of cultural factors influencing prevalence and disclosure of MHPs, this was not reflected in the numbers of BME women identified and treated.	HVs and other professionals need to employ a consistent approach to the assessment and management of MHPs that involves the use of recommended screening tools enhanced by knowledge of cultural factors that might influence maternal disclosure of symptoms or engagement in treatment. This study highlights the importance of contextual factors that compromise collaborative care and makes the case for more opportunities for communication between professionals. Workforce pressure compromise the capacity of HVs to build relationships with mothers and provide appropriate support.
Rothera I, Oates M (2011) Managing perinatal mental health: A survey of practitioners' views. Br j Midwifery 19(5): 304 - 313. https://doi-org.rcn.idm.oclc.org/10.12968/bjom.2011.19.5.304	2011	Postal survey. 768 completed questionnaires (26.7% response rate) were returned from MWs, HVs and obstetricians. The purpose of the study was to ascertain the views of health professionals regarding the identification and management of perinatal MHPs. Location: England	Two thirds of respondents agreed that mild/moderate MHPs could be managed by professionals in primary care. Most of the respondents lacked key skills and knowledge and wanted additional support to help identify and manage MHPs.	HVs need training and access to experts for advice about appropriate management of mothers with MHPs of varying severity.

Jomeen J, Glover L, Jones C, Garg, Marshall C (2013) Assessing women's perinatal psychological health: exploring the experiences of health visitors. Journal of Reproductive & Infant Psychology 31, 479–489. doi:10.1080/02646838.2013.835038	2013	Focus groups with 5 HVs to examine the impact of training on HVs' knowledge, confidence, illness beliefs and empowerment in relation to recognising, assessing and managing psychological and mental health problems in their practice. Location: England	HVs stressed the importance of developing a relationship with women that enabled the use of professional intuition and clinical skills in recognising MHPs. There were mixed views about the value of assessment tools such as the EPDS or the Whooley questions and an assertion that these were only part of the assessment. A common theme was what to do next, once a problem had been identified because mental health services were inadequate and there were no clear referral pathways. This meant that they often felt that they were left supporting women with MHPs that they were not really competent to manage. This could be women who had been referred to, and not accepted by, secondary services or women who had received support from these services but were not any better at the end of the episode of care. In some cases HVs ended up supporting women for years.	HVs in this study felt that, after training, they were better equipped to identify and support mothers with MHPs. The need for clear referral pathways, adequate provision of secondary mental health services and access to experts for advice about management of women with MHPs was highlighted. Lack of appropriate services meant that HVs were sometimes left supporting mothers with MHPs that HVs didn't think that they had the expertise to manage.
Brown M, Reynolds P (2014) Delivery of CBT to treat postnatal depression: health visitors' perceptions. Community Practitioner 87(1): 26 - 29	2014	Focus groups comprised of 9 HVs to explore their perceptions of the use of CBT in the support they provide to mothers with PND. Location: England	All participants understood the fundamental principles of CBT and most felt that all HVs should receive training in CBT in order to standardise the support that is provided, improve the effectiveness of LVs, improve outcomes for mothers and reduce the burden on other services. HVs didn't want their intervention to be described as counselling as they thought that would create a false impression to mothers and others. Whilst most were happy to use CBT techniques during the course of the 6-8 LVs they wanted reassurance that they would receive appropriate training (the 2 days they received was not considered long enough). HVs expressed concern that staff shortages and workload pressures might prevent them form offering CBT informed support to all mothers.	Teaching HVs basic CBT techniques to incorporate into LVs is recommended by the HVs taking part in this study. Adequate training is needed to confer confidence in the application of skills. Workforce pressures may compromise the capacity of HVs to deliver the specified number of visits to all women who need support.
Jones C, Jomeen, J, Glover ., Gardiner E, Garg,D, Marshall C (2015). Exploring changes in health visitors knowledge, confidence and decision-making for women with perinatal mental health difficulties following a brief training package. European Journal for Person Centred Healthcare, 3(3): 384–391. https://doi.org/10.5750/ejpch.v3i3.1012	2015	Mixed methods study involving 72 HVs combining the results from Likert scales and focus groups to explore the impact of half a days training on HV knowledge, confidence and decision-making in their management of mothers with MHPs. Location: England	HVs felt that the mothers who are in the mid-range of severity of MHPs are the ones least likely to want to access support, or for referrals to be accepted by secondary mental health services so it makes it difficult for HVs to know how to help them. The training did give HVs more confidence to manage maternal MHPs including signposting mothers to other services, encouraging them to access peer support, referring to mental health services and working alongside them. The training gave HVs confidence to use the knowledge that they either already had or had gained from the training. More confidence meant that they were more likely to ask more questions about maternal mental health.	HVs who have received appropriate training and support are more confident in exploring maternal mental health issues and considering alternative solutions rather than automatically referring on to mental health services. HV confidence in being able to support women seemed to have a knock on effect of women feeling more confident in taking action to self-manage their MHPs.

Cummings, E., Whittaker, K. (2016) An exploration into the experiences of health visitors delivering listening visits to women as an intervention for mild to moderate postnatal depression or anxiety. Journal of Health Visiting. 4(5): 264-270. DOI: http://dx.doi.org/10.12968/johv.2016.4.5.264	2016	A mixed methods study: 33 HVs completed an on-line questionnaire, 3 HVs participated in semi-structured interviews. Location: England	An average of 4 LVs were offered to mothers to prevent referral, or to support mothers awaiting their first appointment with mental health services. Workload pressures meant that HVs were not always able to offer the number of visits they thought were appropriate, LVs were offered to mothers with a range of risk factors and needs. 88% of HVs felt that LVs helped mothers to recover from anxiety and depression. 76% HVs were confident in their ability to deliver effective LVs. Some HVs were concerned about the severity of mental illness and level of risk they were expected to manage whilst mothers were waiting to be seen by mental health services. Over 80% of HVs had received some training but only 30% thought they had received sufficient training in perinatal mental health. 30% felt that additional training in CBT techniques would be beneficial. 50% of HVs were not able to access appropriate supervision. Concerns were expressed about the difficulty in measuring the effectiveness of LVs.	HVs need training in the delivery of LVs. This should include training in CBT techniques. Access to appropriate supervision is also required. Greater clarity is needed regarding the purpose of LVs and the outcome measures that are used to demonstrate effectiveness.
Ashford MT, Ayers S, Olander EK (2017) Supporting women with postpartum anxiety: Exploring views and experiences of specialist community public health nurses in the UK. Health and Social Care in the Community 25(3): 1257–1264. https://doi.org/10.1111/hsc.12428	2017	Semi-structured interviews with 13 HVs Location: England.	Most HVs were aware of, and used formal screening tools for depression. Only 1 HV was aware of the screening tools for anxiety recommended by NICE. It was noted that it is difficult to differentiate 'normal' anxiety from anxiety warranting more specialist intervention. Lack of training was an issue and HVs felt that they did not have the capacity to cope with mothers with high levels of anxiety. A range of options of additional support were mentioned although the availability of services varied according to location.	More training is needed in perinatal mental health issues in general, and perinatal anxiety in particular. Use of assessment tools might help to identify mothers needing more specialist support.
Morgan M (2017) A qualitative study to explore health visitors' perceptions of listening visits. J Health Visiting 5(10): 506 - 511	2017	Semi-structured interviews with 8 HVs to explore their experiences of delivering LVs	Regardless of level of experience, respondents reported that LVs could be challenging, complex and unpredictable. Motivational interviewing, promotional interviewing and CBT techniques were used during LVs but most of the respondents felt that further education and training was required in the delivery of LVs. Regular updates were recommended. Some HVs had not received any training in how to deliver LVs. HVs also wanted opportunities to discuss and reflect on the support they were providing during LVs. Communication skills and developing a relationship with the mother were considered as essential components of effective LVs. Collaborative care, especially with GPs was also noted as important in the provision of holistic care. Workload pressures influenced capacity to deliver LVs and given the multifactorial causes and presentation of MHPs, LVs may not always be the best option. Monitoring and evaluation of the relevance and effectiveness of LVs was considered important.	HVs need training in how to deliver LVs and opportunities for mentorship and supervision. Systems for monitoring and evaluating LVs need to be put in place. HVs need capacity within their caseload to provide support and liaise with other professionals about maternal MHPs.
Higgins A, Downes C, Carroll M, Gill A, Monahan M (2017b) There is more to perinatal mental health care than depression: Public health nurses' reported engagement and competence in perinatal mental health care. Journal of Clinical Nursing, 27(3–4): e476–e487.	2017	Online survey of 186 (13.6% of target population) PHNs to explore engagement and competence in perinatal mental health care. Location: Republic of Ireland.	39% of PHNs had never received any training in perinatal mental health. 60% reported no guidelines or policies relating to perinatal mental health or did not know if they existed. Levels of knowledge and confidence about various aspects of assessing and managing MHPs varied particularly with regard to questions relating to vulnerability factors such as previous trauma or intimate partner violence and questions about less common symptoms or disorders such as OCD and eating disorders. PHNs deployed 'selective' rather than universal screening. 55% identified care planning as a core dimension of PHN practice. 53% had somewhere to record the care plan in the woman's health record. 30-40% did not provide information to mothers or their partners about MHPs.	Training for HVs must include coverage of the range of MHPs that mothers might experience; the importance of comprehensive, universal, psychosocial assessment; the importance of psychoeducation for mothers and partners; management of MHPs including care planning, monitoring and recording of assessments and outcomes and referral thresholds and pathways.

Noonan M, Galvin R, Doody O, Jomeen J (2017) A qualitative meta-synthesis: Public health nurses role in the identification and management of perinatal mental health problems. Journal of Advanced Nursing 73(3): 545-557. doi:10.1111/jan.13155	2017	14 studies involving 217 participants from 6 countries. (8 studies from the UK)	Public Health Nurses (PHNs) in different countries have different conceptualisations of PND as either different or the same as depression occurring at other times and with a range of possible causes. The EPDS was the most frequently used screening tool that helped to provide structure to the assessment process and increased professional confidence and awareness in assessing and supporting mothers with PND. Additional skills utilised by PHNs included observation of the mother, the baby and the relationship between them and professional intuition that something was 'not right'. Structured assessment increased likelihood of mothers accessing support at other times. The quality of the relationship between the mother and the PHN was considered an essential prerequisite for successful identification of PND with first impressions of particular importance. Antenatal contacts to help establish the relationship, home visits and sufficient time in visits provided circumstances that PHNs considered were conducive to disclosure of symptoms of MHPs. PHNs needed access to supervision and training to maintain their skills. Barriers to the provision of care included lack of clarity regarding whose responsibility it was to manage maternal MHPs; fragmentation of service provision; lack of collaborative care; guidelines/ protocols that did not exist or were not followed; variations in visiting patterns and referral pathways; inadequate provision of secondary mental health services and challenges encountered in assessing and meeting the needs of ethnic minorities. PHNs did not feel that they had the necessary training and skills to support mothers with MHPs.	HVs need adequate and ongoing training and supervision to help consolidate their knowledge and skills in the assessment and management of mothers with MHPs. Training needs to include consideration of cultural differences in the expression of MHPs. HVs need adequate opportunities to develop a relationship with mothers in order to facilitate disclosure. This includes both the number of contacts and the time available in each contact. Clarity is required (from the perspective of the HV, the families they support and the professionals they work with) regarding the role, responsibilities and limits of competence of HVs. Clear policies, protocols and pathways that are accessed and followed by professionals should help to improve awareness of services that are available and how to refer/signpost mothers to them.
Cunningham C, Galloway S (2018) Time for action on perinatal mental health care in Northern Ireland: A report on the perspectives of health visitors and midwives. NSPCC Northern Ireland: Belfast. https://learning.nspcc.org.uk/media/1584/time-for-action-perinatal-mental-health-care-northern-ireland-report.pdf	2018	Survey completed on paper (n=66), on-line (n=266) or by phone (n=1) by health visitors (n= 130) and midwives (n= 202). Location: Northern Ireland	80% of respondents had received training in perinatal mental health. Only 5% of HVs had not received any training. 78% had received training in infant mental health. More than 40% of HVs reported being very confident in their ability to recognize perinatal MHPs.58% describe themselves as 'somewhat confident'. Confidence in recognising PNMI is associated with experience rather than training. 72% of HVs were confident that women with MHPs will receive the help they need. 90% of HVs almost always or quite often use the Whooley questions to assess maternal mental health. 67% HVs almost always or quite often use the EPDS. Almost one in ten respondents spoke about the importance of conversation, listening to women, and observation of non-verbal signs in addition to or as an alternative to the use of screening tools. Top three aids to identifying MHPs according to HVs with caseloads (n = 101) were continuity of relationships, home visiting and screening tools. Three greatest barriers to disclosure according to HVs were fear of consequences, fear of labeling, lack of relationship between professional and patient. 98% HVs offer LVs. 56% of HVs frequently refer women to a community or voluntary services. Challenges to delivering optimal perinatal mental health care cited by HVs were time constraints, capacity and funding (69%),lack of specialist resources/ service provision (25%).	HVs need to have access to regular and updated training that includes opportunities to discuss the process of assessment including the tools that are used. Systemic barriers included insufficient opportunities and time to develop relationships conducive to disclosure, lack of capacity and funding and lack of specialist services to refer women on to.

Higgins A, Downes C, Monahan M, Gill A, Lamb SA, Carroll M (2018) Barriers to midwives and nurses addressing mental health issues with women during the perinatal period: The Mind Mothers study. J Clin Nurs 27(9-10):1872–1883. doi: 10.1111/jocn.14252.	2018	Online or postal survey completed by 809 midwives and nurses (186 PHNs) to explore their perceptions of barriers to provision of perinatal mental health care. Location: Republic of Ireland.	Heavy workloads meant insufficient time to build relationships with women to enable assessment and discussion of MHPs. Lack of clear mental health pathways, inadequate mental health services, limited access to specialist mental health advice. Lack of knowledge and confidence to discuss MHPs; lack of awareness of relevant cultural issues; lack of skill to respond to disclosure; fear about evoking a negative reaction in women or causing offence; concern that asking about mental health would have a negative impact on their relationship with the woman; concern that mothers might think that asking about their mental health should not be part of their role; lack of privacy; were all barriers to nurses and midwives addressing mental health issues.	Organisational barriers such as lack of priority of maternal mental health; workforce capacity leading to insufficient time to assess mental health; lack of training, supervision and access to specialist advice. Comprehensive and regularly updated training is needed on all aspects of assessment and care for perinatal MHPs including exploration of attitudes and concerns of health professionals that might inhibit assessment.
Leonard RA, Linden M, Grant A (2018) Family-Focused Practice for Families Affected by Maternal Mental Illness and Substance Misuse in Home Visiting: A Qualitative Systematic Review.	2018	15 studies involving 571 individuals from 5 countries. (7 studies from the UK). Location: Northern Ireland	Parents want services that are flexible, reliable and family-focussed. Variations in the causes and definition of MHPs add to the complexity of assessment and management. Workforce pressures on HVs and inadequate secondary mental health services may deter HVs from enquiring about maternal mental health. Mental health needs to be considered on a continuum. Child protection priorities favour risk averse management and defensive strategies rather than assessments and interventions focussed on family well-being. The needs of the child 'trump' the needs of the mother. Lack of training undermines HVs ability to provide effective care for mothers with MHPs that incorporates the needs of all members of the family.	HVs need to consider the needs of all family members. Holistic assessments should not be solely based on deficit and risk. Consideration of MHPs should include all MHPs not just depression. HVs need more training in family-focussed mental health assessment and care.
Noonan M, Galvin R, Jomeen J, Doody O (2019) Public health nurses' perinatal mental health training needs: a cross sectional survey. J Advanced Nursing 00: 1 - 13 https://doi.org/10.1111/jan.14013	2019	Postal survey completed by convenience sample of 105 PHNs employed in the Republic of Ireland (46.2% of target population responded) to examine training and support needs with respect to PHN role in perinatal mental health care. Location: Republic of Ireland	77.2% reported good levels of knowledge and 83.8% were confident in assessing stress, anxiety and depression. Most PHNs used a formal screening tool – Whooley questions, EPDS or both. 63.8% would like more education in assessment skills.69.5% and 65.7% wanted additional education about anxiety and depression respectively. 50.5% were confident in providing care for women with perinatal MHPs. 82.7% knew who to contact if a women needed extra support but 51.9% found it difficult to get help for women with MHPs. Most common referral was to GPs, followed by mental health team and counsellors. 59% wanted further education in understanding service options. Preferred mode of education was study days, only 1.9% specified on-line training.	Even though the majority of PHNs in this study reported good levels of knowledge and confidence in assessing maternal MHPs, they still requested further training in how to improve their assessment skills. It might be useful to provide regular opportunities for HVs, either through training, mentorship or supervision to constantly review issues around assessment including the tools used and the additional skills required. 50% of PHNs were confident in providing perinatal mental health care for mothers indicating the need for further training and support. On-line learning was perceived as a useful adjunct to face-to-face study days.

Silverwood V, Nash A, Chew-Graham CA, Walsh-House J, Sumathipala A, Bartlam B, Kingstone T (2019) Healthcare professionals' perspectives on identifying and managing perinatal anxiety: a qualitative study. Br J Gen Prac Sept 23 doi: 10.3399/bjgp19X706025	2019	Semi-structured interviews with 23 health professionals (GPs, MWs, HVs) to explore current practice with regard to the identification and management of perinatal anxiety. Location: England	Some health professionals were not aware of perinatal anxiety as a distinct clinical entity and suggested that it was difficult to differentiate 'normal' perinatal anxiety from pathological anxiety. Opinions varied as to the use, benefits and acceptability of screening tools with some professionals relying on clinical intuition and others suggesting, that because of the associated stigma, mothers may not respond honestly to the questions. The benefits and challenges of interprofessional communication and collaboration were highlighted. Training was raised as an issue either because it was not available, not accessed or too general (not enough information on perinatal anxiety).	All health professionals need access to training and educational resources. An apparent challenge is the need to 'normalise' symptoms of anxiety without 'minimising' their significance. Improved communication and collaboration is required between health professionals in order to be clear about who is doing what and to ensure that mothers experience timely integrated, individualised assessment and care.

TABLE 6.4. MATERNAL PERCEPTIONS AND EXPERIENCES OF PERINATAL MENTAL ILLNESS AND CARE: SUMMARY OF FINDINGS FROM GREY LITERATURE

STUDY	YEAR	STUDY DESIGN AND LOCATION	MAIN THEMES	IMPLICATIONS FOR HV INTERVENTION
Boots Family Trust Alliance (2013) Perinatal mental health: experiences of women and health professionals. http://www.tommys.org/file/Perinatal_Mental_Health_2013.pdf	2013	1547 women who had experienced perinatal mental health problems responded to an on-line survey posted on the Netmums website during Aug/Sept 2012. Location: UK	A quarter of respondents experienced antenatal depression, 2/3 had postnatal depression. Antenatal anxiety was reported by a third and postnatal anxiety by a half. Mothers attributed their symptoms to isolation and unachievable expectations of motherhood.4 in 10 women had suffered with symptoms for more than a year. Low mood and tearfulness were the most common symptoms and experienced by 81% of respondents. Other reported symptoms include appetite changes; anger; difficulty leaving the house; trouble bonding with the baby and suicidal thoughts. 30% of respondents had not told a health professional about their symptoms. 46% had not been completely honest and had just disclosed some of their feelings. 34% of mothers who had hidden their feelings did so because they thought the baby would be taken into care. Other reasons include not seeing the same person, professionals always seemed busy or they just didn't ask mothers how they were feeling. 70% of mothers said the way they were feeling affected their relationship with their partner.	HVs need to provide information to all women about the signs and symptoms of MHPs and the steps mothers can take to maintain their emotional well-being. Many women find it difficult to talk about their symptoms so HVs need to be able to build relationships and provide environments that are conducive to disclosure. The Whooley questions need to be used in the context of a more comprehensive and genuine assessment of mental health that includes exploring the symptoms that are most important to the mother. The impact on other members of the family needs to be monitored and appropriate advice and care provided if necessary. As isolation is such a prominent feature of the maternal experience, HVs need to enable mothers to access opportunities for social contact.
(Khan L, 2015) Falling through the Gaps: Perinatal Mental Health and General Practice. Centre for Mental Health: London. www.centreformentalhealth.org.uk	2015	Report of an on-line survey of 43 GPs conducted via the Royal College of General practitioners in 2014 combined with the results from the survey of 1547 mothers reported in the Boots Family Trust Alliance supplemented with semi-structured interviews with 4 mothers and 3 GPs.	'The biggest barrier to providing better support to women experiencing poor mental health in the perinatal period is low identification of need.' (p.14). GPs working as part of a GP team meant that they had less opportunity to get to know individual patients. Over half of GPs said that they had not received any specific training. GPs wanted more resources to help them address the issue of postnatal depression and felt that conflicting priorities limited their capacity to prioritise postnatal depression. Time pressures were also noted as a disincentive to disclosure by women. Limited access to midwives and HVs by GPs also limited opportunities for collaborative care.	Recommendations relevant to HVs include: universal competency frameworks for all professionals working with mothers with perinatal mental health problems; strategies to reduce pressure on General Practice to enable greater allocation of time to discuss maternal MHPs; more systematic opportunities to focus on maternal and infant mental health and well-being in the first postpartum year; better data collection; clarification of care pathways, clear referral processes and improved provision of perinatal mental health services.

STUDY	YEAR	STUDY DESIGN AND LOCATION	MAIN THEMES	IMPLICATIONS FOR HV INTERVENTION
Oxfordshire 1001 Critical Days Coalition (2016) A Silent Problem. Healthwatch, Oxfordshire. https://healthwatchoxfordshire.co.uk/wp-content/uploads/2018/01/perinatal_mental_health_report_by_oxfordshire_1001_critical_days_coalition.pdf.	2016	An on-line survey of 35 women and 1 man followed up with 4 interviews. The purpose of the survey was to explore perceptions of support for family social and emotional well-being. Location: Oxford, England	Most popular sources of support were Children's Centres, Midwives, HVs and other support organisations. Additional support that respondents would have liked included more support from the HV (not necessarily face-to-face) – more appointments, more time at each appointment, more support regarding breastfeeding, emotional issues, postnatal depression and help with accessing local groups. Perceptions of HV support varied. Comments were made about the unsatisfactory checklist approach to assessment and the perception that you couldn't admit to needing support because the health professionals were too busy to provide it. Lack of continuity of care and lack of collaboration between services was highlighted. Respondents wanted one named key point of contact. Fathers commented that they would have liked to have been asked about their emotional well-being and the impact that having a baby had on them.	Mothers value the support from HVs and would like more appointments and more time at each appointment and a greater emphasis on emotional well-being, breastfeeding and social support. Mothers wanted one named HV who had overall responsibility for their care who would sensitively explore how they were feeling and provide the impression that help is available.

STUDY	YEAR	STUDY DESIGN AND LOCATION	MAIN THEMES	IMPLICATIONS FOR HV INTERVENTION
Russell (2017) Survey: 'Maternal Mental Health - Women's Voices. Royal College of Obstetricians and Gynaecologists: London. https://www.rcog.org.uk/globalassets/documents/patients/information/maternalmental-healthwomens-voices.pdf	2017	2323 women who had given birth in the last 5 years responded to survey distributed via the internet in March 2016.	81% of respondents had experienced at least 1 perinatal MHP. 12% reported that their partner had experienced perinatal MHPs (only 20% of these partners received help for their MHP). 76% of women with no previous history of MHPs went on to experience perinatal MHPs. 95% of women who did have a history of MHPs went on to experience perinatal MHPs. 85% had been asked about their mental health by at least one health professional. 67% were asked about their mental health by their HV. 56% were asked about their history of MHPs. 53% were asked about their personal circumstances. 26% were not asked any background questions. 62% said that they had either talked to a midwife about their mental health or would feel comfortable talking to a midwife. 55% had talked or would feel comfortable talking to a HV. 53% had talked or would feel comfortable talking to a GP. 40% did not feel comfortable because of concern about their mental state being recorded on their medical records. 32% did not feel comfortable because they did not think that the health professional could or would help them. 23% said it was because health professionals were not approachable. 19% said they were not asked. 15% did not want to waste health professionals' time. Mothers felt that they weren't asked about their mental health in an open way, were 'shut down' or had to repeatedly ask for support. Assessments were formulaic and health professionals often appeared busy and rushed. 55% of mothers who experienced MHPs were not referred on to specialist services or other sources of support. For 38% of the women who were referred it took more than 4 weeks to be seen. 48% turned to friends and family for support. 28% accessed an online forum. Mothers reported that their mental health deteriorated with subsequent pregnancies if left untreated or not treated adequately the first time. Gaps in service provision identified by respondents: Lack of knowledge and understanding about perinatal MHPs amongst mothers and health professionals. Preferential focus on depression meant that other symptoms were often not acknowledged. Sometimes it took a while for mothers to realize that something was wrong so would appreciate more support post 6 weeks. Mothers would like health professionals to be more sensitive to the circumstances in which they conduct assessments. For example, not when there are lots of other people present. Assumptions must not be made by the health professional about whether it is appropriate to have the partner/mother/mother-in-law present. Identification questions should provide the foundation for guided conversations, shared decision-making and personalized care. Referrals should be followed up in case they take too long to enact.	Any health professional, including HVs, must understand and ask about the many factors that might predispose to maternal mental ill-health. Identification questions should be used in the context of a more comprehensive assessment that explores all symptoms that mothers might experience. All health professionals must strike a balance between 'normalizing symptoms' and taking them seriously. Due regard must be given to the circumstances surrounding assessment so that the mother can maintain privacy and confidentiality and feels that the health professional is not so busy that they do not have time to listen or do not really want to help. The mental health of other members of the family must be considered as well as the potential impact of the mother's mental state on other members of the family. There must be better liaison between services to ensure that referrals are responded to in a timely manner and to avoid contradictory advice. Mothers must be followed up after discharge from other services. Mothers who do not meet the diagnostic threshold for a more specialist service may still appreciate some help when they are struggling to cope.

STUDY	YEAR	STUDY DESIGN AND LOCATION	MAIN THEMES	IMPLICATIONS FOR HV INTERVENTION
National Childbirth Trust (2018) The Hidden Half: Bringing Postnatal Illness out of Hiding. NCT: London. https://www.nct.org.uk/sites/default/files/2019-04/NCT%20The%20Hidden%20Half_0.pdf	2018	An on-line survey was completed by a representative sample of 1012 mothers with children aged 2 years or less to explore women's experiences of the 6 week postnatal check with their GP. Separate focus groups with GPs and mothers with lived experience of mental illness supplemented the survey findings.	42% of mothers who experienced emotional or mental health problems said that they weren't picked up by a GP or other health professional. 22% of women said that they were not asked about their mental health or emotional well-being at the 6 week GP check. 31% of the women who were asked about their mental health at the 6 week check said it felt rushed and the GPs allocated an average of 3 minutes to the assessment of the mother. Half of the women who had an emotional or mental health problem that they wanted to discuss at the 6 week check did not feel able to because they: were worried that the GP would think they couldn't look after their baby (46%) felt embarrassed or ashamed (37%) assumed that the feeling was normal for a new parent (33%) thought the GP didn't seem interested (28%) thought the GP wouldn't be sympathetic to how they were feeling (24%) thought there wasn't enough time (24%) thought there was no point as nothing could be done (21%). Respondents said that their mental state had an impact on their capacity to cope (85%) their ability to look after their children (59%) and their relationships with their partner (83%) 82% of respondents who received treatment said that it helped.	Whilst this report/survey appears to be solely a campaign for the government to fund and support a dedicated GP check to assess maternal physical and emotional health at 6 weeks postpartum, some of the findings could be applied to the role of the HV. All health professionals who undertake assessments of maternal mental health need to appreciate how hard it might be for mothers to share how they feel and some of the reasons that inhibit disclosure. All health professionals can try to give the illusion that they have time to 'listen' to maternal thoughts and concerns and can strive to indicate interest and empathy. There is always something that can be done even though mothers might feel that this is not the case. Health professionals need to be able to convey a sense of optimism and hope and provide reassurance that even though the mother might be feeling that she is not coping that the purpose of the assessment is to ascertain exactly what the difficulties are that the mother is experiencing and explore with her some ideas and strategies that might help her to feel that she can cope.

6.4. Discussion

6.4.1. Findings from the review of the perceptions and experiences of mothers

Maternal interpretations of the significance of the symptoms that they experience is the starting point for this analysis because maternal uncertainty regarding the relevance and importance of symptoms influences their inclination to share their symptoms and their perceptions of who might be able to help **(GASK ET AL, 2012)**. Acceptability depends on the approachability and expertise of the healthcare provider, the appropriateness of the intervention to alleviate the symptoms of concern, and the willingness of the individual to disclose their symptoms and engage with the proffered intervention **(LEVESQUE ET AL, 2013; SEKHON ET AL, 2017)**.

The majority of studies describe maternal experiences of PND. Rather than the presence of particular symptoms represented in various assessment tools that health professionals are looking for, maternal descriptions of PND often infer an indistinct and insidious onset with gradual accumulation of symptoms and deterioration in mental state.

In a meta-synthesis of 14 qualitative studies, Mollard (2014) suggests a theory of PND that proposes how PND progresses from 'crushed maternal role expectations', through 'going into hiding' and 'loss of sense of self' to 'intense vulnerability' and recommends that interventions need to be tailored to these different aspects of the maternal experience. The sense of loss is referred to in many descriptions of PND and includes reference to loss of control, autonomy, time, appearance, femininity, sexuality, occupational identity, personal freedom and hope **(COATES ET AL, 2014;2015 EMMANUEL & ST JOHN, 2010; HORE ET AL, 2019; O'MAHEN ET AL, 2015; STANEVA ET AL, 2015)**.

Dahl et al (2017) in their meta- ethnographic study based on 10 qualitative studies identified four central metaphors to describe mothers experience of PND: 'feeling trapped by reality', 'experiencing a nameless chaos', 'struggling to find a way out' and 'being seen as a normal but suffering person'. Staneva et al (2015), summarizing the findings from eight studies, depict the broader concept of antenatal psychological distress as progressing from invasive thoughts, recognizing that things are not right, through self-silencing, a state of limbo, spiraling downward and ultimately finding ways to regain control through self-care and a commitment to change. In semi-structured interviews with seven women experiencing anxiety during pregnancy, the uncertainty and uncontrollability of bodily and lifestyle changes precipitated multiple worries about ability to cope during pregnancy, childbirth and parenthood **(HORE ET AL, 2019)**.

Mothers from ethnic minorities highlighted the particular challenges of making sense of their psychological distress in the context of cultural traditions/taboos/religious beliefs; the expectations of extended family; arranged marriages; unsupportive partners; preferential importance of male heirs; isolation from communities and families of origin; the transitional culture shock of migration from a familiar to an unfamiliar lifestyle; and difficulties understanding and negotiating the healthcare system **(DAS, 2019; WITTKOWSKI ET AL, 2017; WATSON ET AL, 2019)**. In some languages there was not a word for depression, or it was not culturally acceptable to express feelings of distress, so these were replaced with somatic symptoms **(WATSON ET AL, 2019)**. Women often experienced a deep sense of loneliness **(SCHMEID ET AL, 2017; WITTKOWSKI ET AL, 2017)**. In a meta-ethnographic review of 256 migrant women's experiences of dealing with PND four expressive metaphors summarised their experiences: 'I am alone, worried and angry – this is not me!'; 'Making sense of my feelings' 'Dealing with my feelings' and 'What I need to change the way I feel!' **(SCHMEID ET AL, 2017)**.

Self-silencing is a common strategy used by mothers to maintain the illusion of a socially acceptable 'happy' and coping individual **(HADFIELD & WITTKOWSKI, 2017; RAYMOND, 2009; STANEVA ET AL, 2015)**. In an Australian study, 18 mothers who had indicated in a survey that they were experiencing moderate to severe levels of anxiety and depression, subsequently asserted that they were feeling 'fine' in response to initial enquiries about their well-being in a face-to-face semi-structured interview. It took between 30 minutes and more than an hour before sufficient rapport was established with the interviewer to enable mothers to share conflicting or negative emotions **(STANEVA & WIGGINTON, 2018)**. McKenzie-Mohr and LaFrance (2011) use the phrase 'tightrope talk' to refer to the difficulties mothers face in balancing their need to talk about how they really feel and their desire to be seen as a confident and capable mother.

Mothers may feel guilty and ashamed of their negative feelings or fear being seen as 'weak, incorrect, abnormal, or incompetent as a mother' **(HENSHAW ET AL, 2011 P.943)**. Health professionals may not appreciate how disempowering and unfamiliar it is for mothers to feel inadequate **(HANNAN, 2016)**. As a result of their inner turmoil mothers may withdraw from others and purposefully avoid contact with friends, family and health professionals, exacerbating their sense of emotional isolation **(HADFIELD & WITTKOWSKI, 2017; HANNAN, 2016)**. The absence of understanding, caring, non-judgemental, well-informed (and therefore helpful) others can leave mothers feeling overwhelmed, scared, lonely and desperate **(STANEVA ET AL, 2015)**.

Symptoms that mothers find difficult to admit to, or understand, include feelings of detachment; loss; emptiness; shame; guilt; despair; distrust; fragility; entrapment; powerlessness; loneliness; unworthiness; frustration; confusion; disillusionment; disappointment; despondency; dejection; inadequacy; resentment; anger; and aggression towards self and others **(HANNAN, 2016; HIGHET ET AL, 2014; PARFITT AND AYERS, 2014; COATES ET AL, 2015; SCHMEID ET AL, 2017; STANEVA ET AL, 2015; JARRETT, 2017; OU & HALL, 2018)**. Variability in symptom expression is a manifestation of how the biopsychosocial changes that accompany pregnancy and motherhood affect women in different ways according to their personality, past experiences, current relationships, cognitive style, sense of self-efficacy, expectations, tolerance of uncertainty, coping skills, cultural norms, and features of the social and physical environment **(BERMAN ET AL, 2014; CHEW-GRAHAM ET AL, 2009; COO ET AL, 2015; FRANKS ET AL, 2017; GARDNER ET AL, 2014; GUARDINO & SCHETTER, 2014; HENDERSON & REDSHAW, 2013; HIGHET ET AL, 2014; HOLOPAINEN & HAKULINEN, 2019; O'MAHEN ET AL, 2015; PATEL ET AL, 2013; REID AND TAYLOR, 2015; FURTADO ET AL, 2019)**.

Questions on assessment tools are not always considered helpful or appropriate by mothers given that many of the symptoms experienced do not 'fit' with the diagnostic criteria for anxiety and depression **(EVANS ET AL, 2017)**. In the 'Born and Bred in Yorkshire Perinatal Depression Diagnostic Accuracy' (BaBY-PanDA) study, women were less likely to give an honest answer to the first Whooley question (Table 6.5.) because it was not considered socially acceptable for an expectant or new mother to feel 'depressed' or 'hopeless' **(LITTLEWOOD ET AL, 2018, P.XXVII)**. Matthey & Agostini (2017), in a critical analysis of the limitations of the EPDS, suggest that the wording of the questions is open to (mis) interpretation as it excludes respondents experiencing significant symptoms because of the use of subjective disqualifying terminology such as 'unnecessarily' and 'for no good reason.' A suggestion arising from an analysis of semi-structured interviews with 17 women (experiencing postnatal psychological distress) was that an honest, respectful chat might be more useful in ascertaining how mothers are feeling, rather than a tick box exercise using a questionnaire that didn't seem to ask the most relevant questions **(COATES ET AL, 2015)**.

TABLE 6.5. WHOOLEY QUESTIONS

Whooley questions	During the past month, have you often been bothered by feeling down, depressed or hopeless? During the past month, have you often been bothered by having little interest or pleasure in doing things?

Mothers only answer truthfully to questions about their mental health if the screening process is clearly explained and they believe that the person asking the questions is open to exploration of their answers and can signpost them to appropriate support **(BOOTS FAMILY TRUST ALLIANCE, 2013; EVANS ET AL, 2017A; HANSOTTE ET AL, 2017)**. Mothers are more likely to talk about how they are feeling in response to pro-active enquiries from health professionals but also experience frustration and disappointment if the anticipated questions are not forthcoming when expected **(AUSTIN ET AL, 2017; RUSSELL, 2017)**. A quote from the 'Falling Through the Gaps' report illustrates this point:

> *'A small number of women described how during 'knife edge' moments of vulnerability, proactive and compassionate questions could promote disclosure.'* **(KHAN, 2015).**

The circumstances accompanying assessment are also viewed as important including sufficient time, privacy and confidentiality **(LEVER TAYLOR ET AL, 2019; RAYMOND, 2009: TURNER ET AL, 2010; SAMBROOK SMITH ET AL, 2019)**. Inclusion of other family members in the assessment process may, or may not, be considered appropriate and helpful by mothers **(DAS, 2019; LEVER TAYLOR, 2019; WITTKOWSKI ET AL, 2011)**.

A recurrent contributory factor to the maternal experience of psychological distress was the mismatch between expectations and reality. Mothers expressed a need for anticipatory, culturally appropriate information about signs and symptoms of common MHPs; aspects of childcare; lifestyle factors associated with the transition to motherhood; the roles and responsibilities of different health professionals, how they communicate with each other and the information they share; the assessment process; and types of support that are available **(BUTTON ET AL, 2017; DAHL ET AL, 2017; DAS, 2019; GARDNER ET AL, 2014; HADFIELD & WITTKOWSKI, 2017; HANSOTTE ET AL, 2017; HOLOPAINEN & HAKULINEN, 2019; NEWMAN ET AL, 2019; PATEL ET AL, 2013; PLUNKETT ET AL, 2016; SAMBROOK SMITH ET AL, 2019; SCOPE ET AL, 2017; WATSON ET AL, 2019)**.

Some mothers have reported that they do not feel listened to, understood, or cared for, by health professionals, who appear stressed, rushed, brisk, critical, unable or unwilling to help, have their own agenda, and ask questions in an insincere and formulaic manner **(BOOTS FAMILY TRUST ALLIANCE, 2013; COATES ET AL, 2014; RAYMOND, 2009; RUSSELL, 2017; SLADE ET AL, 2010; TURNER ET AL, 2010)**.

Negative perceptions may arise from misunderstandings, previous unsatisfactory encounters, current treatment, or increased vulnerability related to the experience of psychological distress **(BUTTON ET AL, 2017; HADFIED & WITTKOWSKI, 2017; HANSOTTE ET AL, 2017)**. In a secondary analysis of data collected from 5,332 English mothers at 3 months postpartum, mothers with antenatal or postnatal anxiety were more likely to report that health professionals did not treat them with kindness or respect **(HENDERSON & REDSHAW, 2013)**. In a cross-sectional survey of 71 U.K. first-time mothers, an inverse association was found between PND and maternal satisfaction with both postnatal care and positive perceptions of HV communication **(MCLELLAN & LAIDLAW, 2013)**.

Mothers want health professionals to help them to understand their symptoms in the context of the many and varied contributory factors that might indicate a MHP and the impact of symptoms on daily functioning, relationships and circumstances **(4CHILDREN, 2011; CHEW-GRAHAM ET AL, 2009; COATES ET AL, 2015; FRANKS ET AL, 2017; FURBER ET AL, 2009; HANSOTTE ET AL, 2017; PLUNKETT ET AL, 2016)**. Mothers in several studies wanted the opportunity to talk about financial problems, relationship difficulties, multiple roles and tasks, social isolation, sleep, exhaustion, feelings towards their child and managing the transition to parenthood **(JEVITT ET AL, 2012; MOLLARD, 2014; O'MAHEN ET AL, 2015; TURNER ET AL, 2010)**. Sensitive enquiries and compassionate responses to alleviate anxieties and dispel myths are appreciated **(HENDERSON, JOMEEN ET AL, 2018; HORE ET AL, 2019; NEWMAN ET AL, 2017; RUSSELL, 2017)**.

Emmanuel and St John (2010), in their concept analysis of maternal distress, recommend that nurses and MWs should acknowledge and normalise maternal feelings of distress rather than problematize them or seek to label them as a clinical condition. Although mothers want to know that their experiences are not abnormal, premature or inappropriate 'normalization' shuts down further discussion and leaves mothers feeling dejected and isolated **(EVANS ET AL, 2017; NEWMAN ET AL, 2019)**. Professionals need to be able to negotiate the delicate balance between normalizing symptoms and acknowledging distress **(EVANS ET AL, 2017; NEWMAN ET AL, 2019; RUSSELL, 2017)**.

Relationships that foster continuity, containment, comfort and trust are valued by mothers, are conducive to disclosure and increase motivation to explore possibilities and engage with therapeutic activities **(HADFIELD & WITTKOWSKI, 2017; JONES ET AL, 2015)**. In semi-structured interviews with 23 pregnant or postpartum American mothers, maternal assessments of the clinician's technical competence, genuineness, warmth and the ability to instil hope determined maternal engagement with therapy. The most important component of the clinical encounter was identified as 'sufficient listening' **(HENSHAW ET AL, 2011)**. This included demonstrating a willingness to hear the client's story, not giving premature advice and valuing the client contribution to decisions about treatment choice.

Mothers wanted help even if they did not cross the threshold for support **(COATES ET AL, 2015; RUSSELL, 2017)**. As it often takes time for mothers to make sense of their symptoms and reach the stage where they are ready to ask for, or accept help, mothers want opportunities to talk about their distress beyond the 6 week postnatal check **(RUSSELL, 2017)**.

Support was considered more acceptable if it was delivered in the home and more beneficial if it was offered by a named health professional who was perceived as knowledgeable about motherhood and mental health and could provide reliable and consistent support **(DAHL ET AL, 2017; HADFIELD & WITTKOWSKI, 2011; HANSOTTE ET AL, 2017; LAW ET AL, 2018; O'MAHEN ET AL, 2015; OXFORDSHIRE 1001 DAYS COALITION)**. The promise of support can improve outcomes even before the first session has been delivered **(TAYLOR, 2000)**. The importance of first impressions regarding the trustworthiness of the practitioner and the usefulness of therapy is further suggested by research that indicates that the majority of clients do not proceed with therapy after preliminary assessment **(BARKHAM ET AL, 2011)**. More clients disengage from therapy after one session than at any other time **(SIMON & LUDMAN, 2010)**. Mothers need to know that the support that is being offered is worth the investment of their time and energy and is likely to culminate in beneficial outcomes **(HADFIELD & WITTKOWSKI, 2017; MEGNIN-VIGGARS ET AL, 2015)**. Mobilization of hope is a key factor in facilitating recovery.

Mothers receiving LVs (based on NDC) from HVs in Oxfordshire inferred that their motivation to engage with LVs was influenced by their relationship with their HV. Maternal perceptions of the unstructured nature and lack of purpose of LVs led to premature disengagement (Shakespeare et al, 2006). Recommendations from this study include the need for HVs to be more explicit about the intended purpose and outcome of the intervention and to incorporate additional techniques within their 'therapeutic toolbox' such as problem solving and CBT **(SHAKESPEARE ET AL, 2006 P.160)**. In the RESPOND trial, mothers did not think that it would have been appropriate for their 'usual' HV to deliver the LV intervention **(TURNER ET AL, 2010)**. The majority of women receiving LVs from a research HV found that 8 visits were not sufficient to confer recovery, implying that LVs (based on NDC) were not therapeutic **(TURNER ET AL, 2010)**. In the PoNDER trial 40% of eligible mothers declined the offer of a HV intervention **(SLADE ET AL, 2010)**. Semi-structured interviews with 30 women who would have been eligible for the HV intervention in the PoNDER trial revealed that those who declined support did not think that the HV had the necessary knowledge, skills or qualities to be able to help **(SLADE ET AL, 2010)**.

Preferred interventions have clear parameters with regard to structure, process and anticipated outcomes with an inherent flexibility to adapt the dose, format and mode of delivery to maternal needs, preferences and circumstances **(SCOPE ET AL, 2017)**. Mothers want interventions that do not require too much effort or burdensome homework **(BHAT ET AL, 2018; O'MAHEN ET AL, 2015; LAW ET AL, 2018)**. As premature termination of interventions might lead to maternal concerns about subsequent capacity to cope, preparation for endings and supportive follow-up sessions are considered helpful **(HADFIELD & WITTKOWSKI, 2017; SCOPE ET AL, 2017; TURNER ET AL, 2010)**. Maternal perceptions of components of optimal perinatal mental health care include support from partners, family, friends and social networks; community-based support; integrated parenting and well-being interventions; mind-body exercises; general lifestyle interventions; and the establishment of a trusting relationship, realistic expectations, practical, manageable goals and sustainable coping strategies **(BHAT ET AL, 2018; DAHL ET AL, 2017; HADFIELD & WITTKOWSKI 2017; HANSOTTE ET AL, 2017; PLUNKETT ET AL, 2016; SCOPE ET AL, 2017)**.

6.5.2. Findings from the review of the perceptions and experiences of health visitors

The first step in the process of providing support is the identification of mothers with additional mental health needs. Clinicians need to be aware of the experiences, understanding, motivation and biases of the mother that they are assessing and appreciate that their assessment may be influenced by their own experiences, understanding, and bias **(TRENOWETH ET AL, 2017)**.

HV perceptions of barriers to sensitive, effective perinatal mental health assessment include lack of consensus on the validity, appropriateness and correct use of recommended assessment tools; variations in confidence, competence and comfort in exploring sensitive issues; lack of time and pressure of workloads predisposing to failure to develop rapport; fragmented services that predispose to abdication of responsibility for the provision of care; a sense that it is not ethical to ask the questions if you don't know what to do with the answers; and treatment services that are needed are not available or difficult to access **(CUNNINGHAM & GALLOWAY, 2018; CHEW-GRAHAM ET AL, 2009; EDGE, 2010; HIGGINS ET AL, 2017; JOMEEN ET AL, 2013; NOONAN ET AL, 2017; SAMBROOK SMITH ET AL, 2019; SILVERWOOD ET AL, 2019)**.

The reservations expressed by mothers are echoed by HVs who also affirm the importance of a trusting, collaborative relationship as the foundation for a sensitive, comprehensive assessment, and caution against an over-reliance on screening tools such as the Whooley questions, GAD2 and EPDS **(BOOTS FAMILY TRUST ALLIANCE, 2013; EDGE 2010; JOMEEN ET AL, 2013)**. Studies reveal that intuition and clinical skills are used as an adjunct to screening tools, or screening tools may be limited to use with selected mothers who appear to be at increased risk of developing a MHP **(CUNNINGHAM & GALLOWAY, 2018; EDGE, 2010; HIGGINS ET AL, 2017; JOMEEN ET AL, 2013; NOONAN ET AL, 2017; SILVERWOOD ET AL, 2017)**.

Whilst HVs recognise that assessment should include enquiries about the multiple and complex factors that might contribute to maternal psychological distress, concerns are also raised about the difficulties of exploring sensitive issues; identifying less common MHPs; understanding and overcoming language and cultural barriers; evoking a negative reaction or causing offence; distinguishing between mothers who can be helped to manage their distress and those who require more specialist services; and considering the mental health needs of other family members **(ALMOND & LATHLEAN, 2011; EDGE, 2010; HIGGINS ET AL, 2017 & 2018; LEONARD ET AL, 2018; MORRELL ET AL, 2009)**. HV awareness of the importance of observing mother-infant interaction as an integral component of comprehensive assessment is tempered with the knowledge that vulnerable mothers may interpret their actions as judgemental surveillance rather than as a prelude to providing sensitive support **(NOONAN ET AL, 2017)**.

HVs consider that antenatal contacts, sufficient number of contacts, sufficient time in visits and home-based assessment and care are all conducive to the formation of relationships that enable women to share how they feel **(CUNNINGHAM & GALLOWAY, 2018; HIGGINS ET AL, 2018; NOONAN ET AL, 2017; SAMBROOK SMITH ET AL, 2019)**. Systemic barriers include absence of, or inadequately implemented, local guidelines and protocols, staff shortages, excessive workloads and lack of specialist services **(CUNNINGHAM & GALLOWAY, 2018; HIGGINS ET AL, 2018; JOMEEN ET AL, 2013; NOONAN ET AL, 2016; SAMBROOK SMITH ET AL, 2019)**.

A mixed methods study seeking the views of 36 HVs about their experience of delivering LVs revealed a commitment to support mothers with MHPs, but uncertainty about the best techniques or models to use during the course of visits and concerns about lack of supervision, training, standardized outcome measures and a consistent approach **(CUMMINGS & WHITTAKER, 2016)**. A qualitative study of 8 HVs exposed similar concerns about the lack of specific training dedicated to the delivery of LVs although it was acknowledged that transferable skills from other training opportunities gave HVs a 'toolbox' of techniques that they could use such as motivational interviewing, promotional interviewing and CBT techniques **(MORGAN, 2017)**. HVs who participated in training in CBT techniques felt that these would improve the effectiveness of LVs as long as adequate training (more than 2 days) and supervision was provided **(BROWN & REYNOLDS, 2014)**.

Jones et al (2015), in a post-training impact analysis on 72 HVs found that half a day of training in perinatal mental health care improved their knowledge, confidence and skills. Higgins, Downes et al (2017) in their survey of 186 HVs found a statistically significant relationship between perceived confidence and skills and training in perinatal mental health. This association was not significant in a survey conducted a year later with 105 HVs from the same target population **(NOONAN ET AL, 2019)**. Nearly 30% of HVs who had received 8 days of training and delivered either the PCA or CBA based intervention in the PoNDER trial were not confident in their ability to identify and support mothers with MHPs at the end of the trial **(MORRELL ET AL, 2009)**. Confidence is important because HVs have to be convinced, and convincing, about the content and benefits of the intervention they are offering

(MORRELL ET AL, 2009). A mother needs to believe that the HV will understand what her issues are and has the technical competence to explore/suggest solutions that might be helpful (JOYCE ET AL, 2003). When therapists believe in their clinical approach and can communicate that approach in a simple, understandable, and convincing manner, clients perceive them as having more technical expertise (BECK ET AL, 1979; HENSHAW ET AL, 2011).

The majority of both quantitative and qualitative studies included in the review attest to HV perceptions of the inadequacies of current perinatal mental health training provision with regard to insufficient time allocated to learning the skills needed to deliver interventions in general; the absence of information about interventions to manage MHPs other than depression; and the variable capabilities and characteristics of trainers (ASHFORD ET AL, 2017; CUNNINGHAM & GALLOWAY, 2018; HIGGINS ET AL, 2017; MORRELL ET AL, 2015; NOONAN ET AL, 2019; PRICE ET AL, 2012; SILVERWOOD ET AL, 2019).

Training may be important but will not be effective if contextual factors that influence the capability, opportunity and motivation of HVs to identify need and provide support are not also addressed (JOMEEN ET AL, 2013; PRICE ET AL, 2012). Managers need to acknowledge the temporary impact on workforce capacity whilst new interventions are embedded in systems and practice (WELLS ET AL, 2012). Guidance and encouragement from peers is needed to facilitate practice of the newly learnt intervention quickly and frequently enough to consolidate knowledge, confidence and skills (ENGLAND ET AL, 2015; PRICE ET AL, 2012).

Interventions may not be compatible with the trainee's preferred way of working; previous training and clinical experience; assumed scope of practice and limits of competence; or personal beliefs about mental illness and/or the relevance and effectiveness of the intervention (JOMEEN ET AL, 2018; PRICE ET AL, 2012; WADEPHUL ET AL, 2018). HVs might be inhibited from assessing mental health because they are anxious about their ability to respond to mental health issues and not aware of the range of support that is appropriate and available (JOMEEN ET AL, 2013). HVs who are feeling overwhelmed or are struggling with mental health issues themselves may not have the emotional capacity to respond to maternal psychological distress. As one HV respondent stated in a survey involving 130 HVs from Northern Ireland:

> *'Lack of professional resilience skills leading to being "too busy" and stressed, professionals have learnt behaviour of being full up, the woman is therefore not seen, heard or understood. Greatest challenge is enabling practitioners to be mindful and reflective with an openness to change.'* (CUNNINGHAM & GALLOWAY, 2018 P.44).

Lack of mentorship and reflective, restorative supervision aggravates the challenges of assessing maternal need, risk and progress and knowing when to refer mothers on to more specialist services (MORGAN, 2017). Willis (2018), in her review of LVs, highlights the lack of clear instructions in the NICE guideline regarding how, and by whom, mothers with MHPs should be identified and supported. This uncertainty, exacerbated by disparity of training availability and shortage of HVs, predisposes to variations in HV practice regarding the techniques that are used, and the purpose, duration and frequency of visits offered. Willis (2018) suggests that further investigation is needed into interventions that HVs can deliver that help mothers to feel better.

6.5. Strengths and limitations

A strength of this literature review is the integration of the views and experiences of both HVs and mothers and the opportunity to see where they diverge or coalesce. The point of the literature review is to consider how these different perceptions and experiences can lead to a new or different understanding of what should be included in an intervention that meets the needs of mothers with MHPs.

The strengths of a hermeneutic approach to a literature review lie in its expansive rather than exhaustive nature and an acknowledgement that it is likely that any literature identified only represents a tiny proportion of all that it might be useful to know about a given topic. Hermeneutics, as the art and science of interpretation, requires that the researcher is open to possibilities and serendipitous discoveries. This means that literature may be included that captures the attention of the researcher even though it might be out-with the parameters of a more traditional and clearly defined review.

In the search for greater understanding, unexpected discoveries can capture the researcher's attention. For me, concepts that emerged from this exploration of the literature, and really made me think about how I was going to interpret and present my findings, are the 'crisis of representation' **(SANDELOWSKI, 2006)** and 'tightrope talk' **(MCKENZIE-MOHR & LAFRANCE)**. A strength of the review might therefore be an acknowledgement of the challenge of authentic representation of the lived experience of others. A limitation is the inadequacy of the overview to capture what people really want to say, but might find it difficult to express, or to include what Sandelowski (2006) describes as the 'voices of the voiceless'.

Hermeneutic literature reviews attract criticism because of the flexible systematic approach that potentially conspires against replication. Equally, criticisms have been levied at conventional systematic reviews that have been described as 'redundant, misleading and conflicted' **(IOANNIDIS, 2016 P. 485)** Greenhalgh & Peacock (2005 p. 1065) suggest that strategies such as 'browsing library shelves, asking colleagues, pursuing references that look interesting, are more likely to identify relevant sources of information than a more conventional literature review. This is a comparable process to a hermeneutic literature review that nevertheless has a systematic starting point for the identification of appropriate articles from which the citation searching can ensue (Fig 6.1). The strengths of this review are that the key features of foundational articles are presented so that readers of this review can appreciate the content and relevance of the articles referred to in the discussion.

6.6. Conclusions

Thirsk & Clark (2017 p.5) suggest that Gadamer asserts that what is important 'is the amount of new information that the researcher can gather – from a variety of sources – to further understand the topic in general' **(THIRSK & CLARK, 2017 P.5.)**. New information relates to some 'thing' that is new, or a new way of looking at a 'thing' that already exists. The purpose of this research is to expose new information about LVs, to interpret them from multiple perspectives, in order to re-imagine them in a different way.

An integrated synthesis of multiple sources of evidence regarding the views of HVs and mothers has provided insights into how the experience of delivering and receiving perinatal mental health care can be improved for both parties. The need for sensitive responsive assessment has been identified. As has been indicated in the previous chapter greater emphasis needs to be placed on the development of a shared understanding of symptoms and issues and the achievement of specific goals allied to the agreed purpose of the intervention(s). This is determined by the quality of the relationship between the mother and the HV. A multidimensional approach is needed to respond to the unique needs, preferences and circumstances of mothers.

This review indicates that HVs need additional training with regard to not only the content of assessments and interventions but also how to foster environments and relationships conducive to disclosure and collaboration. This must include modifying features of the working environment that compromise the capacity of HVs to provide sensitive, responsive care.

6.7. Chapter summary

This chapter has extended the parameters of the hermeneutic literature review to provide the foundation for an investigation into maternal experiences of perinatal mental illness and care and HV perceptions and experiences of providing that care. It has highlighted that perhaps there is a disconnect between what mothers might find helpful, what it is possible for HVs to do, and what HVs want to do, or feel able to do. Lack of training is repeatedly highlighted as an important issue.

It would appear that the most salient determinant of an effective and acceptable intervention is the collaborative understanding that relies on the establishment of a trusting relationship. As Johnson and May (2015) assert 'complex interventions in complex settings tend to be implemented through collective action that takes place when people work together, rather than as a result of individual behavioural processes **(JOHNSON & MAY, 2015 P.2)**.

This is perhaps the most important chapter in the consideration of the constituent parts that contribute to our understanding of what is needed in the future. Collaborative action is not just about the relationship between the mother and the HV, although that is important, but the relationships between the mother and others, and the HV and others and everybody that makes up the complex social system within which the mother resides and the HV intervention is offered. HVs are not only concerned about their capacity to manage maternal MHPs but also the availability, accessibility, acceptability and appropriateness of other services. Focussing on what HVs do is an important first step in optimising action focussed on prevention and early intervention and improving family emotional wellbeing. However, the ability of HVs to ensure prompt access to appropriate care is also determined by the extent of co-operation and understanding between professionals and a shared commitment (and capacity) to provide collaborative, integrated care.

The review of the literature described in this chapter indicated a greater volume of literature relating to the views and experiences of mothers compared to the literature available on the views and experiences of HVs. Surveys of HV knowledge and practice were conducted in the Republic of Ireland and Northern Ireland **(CUNNINGHAM & GALLOWAY, 2018; HIGGINS ET AL, 2017, NOONAN ET AL, 2019)**. Apart from a mixed methods study involving 33 HVs **(CUMMINGS AND WHITTAKER, 2016)** and the intelligence acquired from qualitative research **(ASHFORD ET AL, 2017; BROWN & BACIGALUPO, 2006; BROWN & REYNOLDS, 2014; MCCONNELL ET AL, 2005;MORGAN, 2017)** there is very little information available about current HV perinatal mental health practice in the rest of the UK. An examination of current HV perinatal mental health practice is the focus of the next chapter.

Chapter 7. Examining Current practice and Context

7.1. Introduction

This thesis is fundamentally about the role of health visitors in supporting mothers with MHPs. The main questions that need to be answered revolve around the topic of LVs. This is because HVs have been offering LVs to mothers with PND since 1989 but owing to changes in the recommendations in the NICE guideline it is not clear whether they should continue to do so (Chapter 3).

The extent to which NICE guideline recommendations in general, and the recommendations in the NICE guideline for antenatal and postnatal mental health, in particular, determine health visiting practice, is not known. Gabbay & LeMay (2011) suggest that primary care clinicians do not necessarily have the time to access and appraise tacit and explicit sources of knowledge (such as protocols or guidelines). HVs may not be aware of the recommendations in the NICE guideline, may only be aware of the implications of the recommendations in the guideline if their commissioner or managers have specified that LVs should not be offered, or are aware that NICE recommendations are not mandatory and do not over-ride patient preference and clinical judgement, and therefore may not impact on the delivery of LVs **(NCCMH, 2014)**.

One criticism levied at NICE guidelines is that they do not allow for multiple morbidities or individual idiosyncrasies. Clinicians have to combine information from a wide range of sources, and from each other, to develop their own sequences of thought and behaviour (clinical mindlines), to respond appropriately to the patient in front of them **(GABBAY & LE MAY, 2011)**. Every clinician has to interpret evidence, according to their own implicit and unconscious biases; the training they have accessed; the influence of significant others; conflicting workplace demands and priorities; the popularity of non-research-informed local innovations; and the requirements of the system within which they operate **(GABBAY ET AL, 2020)**.

An exploration of the prevalence and impact of maternal MHPs and the views and experiences of mothers has also indicated that the way maternal mental health needs are experienced and expressed may not be compatible with diagnostic criteria (Chapter 3, chapter 6). Interventions, such as LVs, based on these criteria, may not be appropriate (Chapter 6). LVs were originally intended to treat PND. RCTs to test the effectiveness of LVs do not provide evidence to indicate the relevance and impact of LVs for other manifestations of maternal psychological distress (Chapter 3). This provides another reason for reviewing the content and purpose of LVs.

Interventions develop in different ways, in different places, as a result of changing contexts and needs, so that different versions of the same intervention may co-exist. This doesn't mean that any one version is better than any other. Each version may confer specific benefits and disadvantages. However, an intervention that is poorly or multiply defined may be difficult for practitioners to operationalise or set clear and realistic outcomes **(HOFFMAN ET AL, 2014)**. Bauman et al (1991) suggest that If an intervention has been adapted to the extent that it no longer bears a resemblance to the original and does not confer expected benefits, it has entered 'the zone of drastic mutation' with associated confusion about what the intervention is or how it is supposed to work.

There is some evidence to suggest that HVs have adapted the LV intervention to respond to changing maternal mental health needs and preferences and enhanced awareness about additional strategies and techniques that might be effective **(CUMMINGS & WHITTAKER, 2016; IHV, 2014; NOONAN ET AL, 2016).** Variations in health visiting perinatal mental health practice obviously exist but the causes, extent and continuum of variation across the UK is not known.

Bleijenberg et al (2018), in their proposed 5th stage of the enriched development phase of the MRC guidance for complex interventions, suggest that identifying 'existing intervention practice is extremely valuable during the development process' in order to 'optimise the successful delivery of an intervention within its context' (p.90). The purpose of this chapter is therefore to explore how the LV intervention can be optimised by investigating what HVs are doing at the moment, what they think about what they are doing, the factors that influence what they do, and what they think they ought to be doing in the future. The method chosen to explore these issues was an online survey.

The rest of this chapter describes the aims and objectives of the survey; how the survey was created and distributed; how the findings were analysed; the conclusions that were drawn; how the findings from this stage of the research complement the findings from the previous stages; and the potential implications for health visiting perinatal mental health practice.

The STROBE (Strengthening the Reporting of Observational Studies in Epidemiology) standardized reporting guidelines: cross sectional studies – were used to guide the conduct and reporting of this study **(VON ELM ET AL, 2007).** As the survey was an on-line survey, elements of the STROBE reporting guidelines were combined with items from the CHERRIES (CHEcklist for Reporting Results of Internet E-Surveys) checklist **(EYSENBACH, 2004).**

7.2. Survey aims and objectives

AIM: TO CLARIFY THE ROLE OF THE HV IN SUPPORTING MOTHERS WITH MHPS, ESPECIALLY WITH REGARD TO THEIR PERCEPTIONS AND DELIVERY OF LVS.

OBJECTIVES:

- To ascertain whether HVs believe that supporting mothers with MHPs should be an integral part of their role.
- To explore the factors that might enhance or compromise the capacity of HVs to identify and support mothers with MHPs;
- To determine whether HVs believe that they have the necessary knowledge and skills to support mothers with MHPs;
- To describe the current beliefs, attitudes and practice of HVs with regard to how they understand, organize and deliver the support they provide to mothers with MHPs, whether or not this support is described as LVs;
- To describe the core components that HVs think should form the basis of a health visitor-led intervention;
- To explore what HVs believe is needed to enable them to provide effective support to mothers with MHPs.

7.3. Method

7.3.1. Ethical considerations

The study was approved by the Faculty of Health and Life Sciences ethics committee at Oxford Brookes University (FREC study number 2014/58). All participants were provided with information about their rights as a participant and were required to confirm consent to participate either in paper form (to be returned with the completed postal questionnaire) or by 'clicking' on the appropriate button prior to commencement of the on-line survey (see appendix 2 for all documentation relating to the survey, including ethics approval).

Permission was sought and granted from the Director of the IHV to distribute the survey (see letter in appendix 2).

7.3.2. Survey design

A cross-sectional design was used in this study employing a convenience sampling strategy with a purposive element. The purposive element involved targeting health visitors with particular expertise in perinatal and infant mental health.

7.3.3. Survey content

7.3.3.1. CONTENT VALIDITY

The survey was designed specifically for this study. The questions included in the survey were informed by discussions with health visitors; a review of the literature; the requirements specified by the updated NICE guideline regarding the delivery of psychological and psychosocial interventions **(NICE 2014A, RECOMMENDATION 1.7)**; the health visiting core service specification 2015/16 **(NHS ENGLAND, 2014A)**; the briefing issued by the IHV in response to the launch of the NICE guideline **(IHV, 2014)**; the principles underpinning the MRC guidance for complex interventions **(CRAIG ET AL 2008; MOORE ET AL 2015)** and the 12 domains of the original Theoretical Domains Framework (TDF) **(MICHIE ET AL 2005)** (Table 7.1). The survey was reviewed by five key informants with expert knowledge of the role of HVs in supporting mothers with MHPs. Amendments were made in the light of this feedback and in response to recommendations from the PhD supervisory team and the chair of the ethics committee.

TABLE 7.1. DOMAINS OF THE THEORETICAL DOMAINS FRAMEWORK (MICHIE ET AL, 2005)

1	Knowledge
2	Skills
3	Social/professional role and identity (self-standards)
4	Beliefs about capabilities (self-efficacy)
5	Beliefs about consequences (anticipated outcomes/attitude)
6	Motivation and goals (intention)
7	Memory, attention and decision processes
8	Environmental context and resources
9	Social influences (norms)
10	Emotion
11	Behavioural regulation
12	Nature of the behaviour

The Theoretical Domains Framework

To overcome the daunting prospect of trying to make sense of the multiple factors influencing the delivery of complex interventions in complex adaptive systems, the MRC recommend the use of an explicit theoretical framework to guide the research process **(CRAIG ET AL, 2008)**. Selecting relevant theories or frameworks is itself a complex endeavour. As LVs are essentially about what HVs say, think and do in response to maternal thoughts, feelings and behaviour, a theoretical framework was selected that integrates the behavioural change theories considered most relevant to exploring the implementation of interventions **(ATKINS ET AL, 2017)**.

The TDF has been used in a broad range of studies as a mechanism for systematically examining determinants of practice **(FRANCIS ET AL 2012)**. The TDF was developed through expert consensus and represents a synthesis of 128 constructs from 33 psychological theories grouped into 12 domains **(MICHIE ET AL 2005)** (Table 7.1.). It facilitates the identification of 'all aspects of possible influences' on health professional practice so that modifiable barriers and enablers of practice can be identified **(PHILLIPS ET AL, 2015. P.142)**. Although the TDF was modified to include 14 domains **(CANE ET AL, 2012)**, it has been suggested that the original version might provide a more comprehensive overview of barriers to the effective implementation of clinical interventions **(HUIJG ET AL, 2014; MOSAVIANPOUR ET AL 2016)**.

As one of the issues with 'listening visits' is the challenge of describing exactly what is included in the intervention it was also considered appropriate to use the original version of the TDF in the investigation of HV perinatal mental health practice as this includes the domain 'nature of the behaviour,' whereas the second version does not. The original version of the TDF was therefore used in this study to contribute to the design of the survey questionnaire and facilitate systematic analysis of the free text responses.

7.3.3.2. FACE VALIDITY

A link to the test version of the survey was sent to 17 associates with varying levels of experience in the field of health visiting, perinatal mental health and research, to check relevance, readability and ease of completion. Further amendments were made in response to feedback.

The final version of the survey included 40 questions distributed over 5 sections: health visitors and mental health (6 questions); training in perinatal mental health (3 questions); listening Visits (18 questions); the Future (6 questions); about you (6 questions). A variety of question formats were used including binary, likert, matrix, semantic differential and multiple choice. Semantic differential questions were used to explore HV attitudes towards the utility, acceptability and effectiveness of LVs as it has been demonstrated that attitudes exert a significant effect on both intention and behaviour **(MCEACHAN ET AL, 2016)**. Nine of the 40 questions were open-ended questions (see appendix 2 for copy of the survey).

7.3.4. Participants

Participants were members and perinatal and infant mental health champions registered with the Institute of Health Visiting (IHV). The aim of the IHV is to raise standards in health visiting practice and to improve outcomes for children and families. Any practitioner working in the field of health visiting can become a member of the IHV. In order to become a champion, HVs with a special interest in perinatal and infant mental health are required to attend centralized training and then cascade the training to HVs in the areas where they work. Champions are not necessarily members of the IHV.

The IHV provided members and champions with an electronic link to the survey between March and May 2016. Started surveys remained open for 1 month to allow frequent returns and encourage completion. Acknowledging best practice to increase response rates **(NAKASH ET AL, 2006)** repeat invitations to participate were sent electronically by the IHV to all potential respondents on three occasions during the two month time frame.

7.3.5. Data collection

Data was collected using an anonymous, on-line self-completion questionnaire located on the Qualtrics survey platform **(QUALTRICS, PROVO, UT, 2016)**. A link to an electronic survey was sent to the members and perinatal and infant mental health champions of the IHV, March – May 2016.

HVs attending IHV perinatal and infant mental health champions meetings that the main investigator (CL) was invited to, to explain her research, were offered the option of completing a paper questionnaire and then returning it by post. Postal responses were entered manually onto the Qualtrics platform.

7.3.6. Data analysis

Tableau software was used to translate the work postcodes of the respondents into a pictorial representation of their geographical distribution. Descriptive statistics were used to present the quantitative data.

The free text responses were examined by all members of the research team and then imported into the NVIVO11 software platform to facilitate content analysis. Systematic coding commenced following familiarization with the data **(BRAUN & CLARK, 2006)**. Responses were contemporaneously coded into inductively generated themes and the 12 domains of the Theoretical Domains Framework (Table 7.1). Inductive coding ensured the inclusion of data that did not seem to fit with the pre-defined codes **(GALE ET AL 2013)**.

On completion of coding of the first two open-ended questions (n=960 responses), the process and coding logic were reviewed and discussed by the research team. Further review and discussion informed the subsequent coding process.

The high volume of free text responses (n = 3,569) was not anticipated. Whilst the depth and diversity of comments add contextual richness to the quantitative findings, thereby minimising researcher interpretation bias **(CRESWELL ET AL, 2011)**, this also meant that an additional approach to analysis was required. A decision was therefore made to subcategorise the TDF category 'the nature of the behaviour' according to the 12 items of the TIDieR (Template for Intervention Duplication and Replication) checklist **(HOFFMAN ET AL, 2014)**. There is significant overlap between the domains of the TDF and the items of the TIDieR checklist. The purpose of the additional categorisation was to ensure that the features of LVs described by respondents were allocated to categories commensurate with the international consensus regarding the essential elements that should be included in descriptions of interventions **(HOFFMAN ET AL, 2014)**.

The Template for Intervention Duplication and Replication (TIDieR) checklist

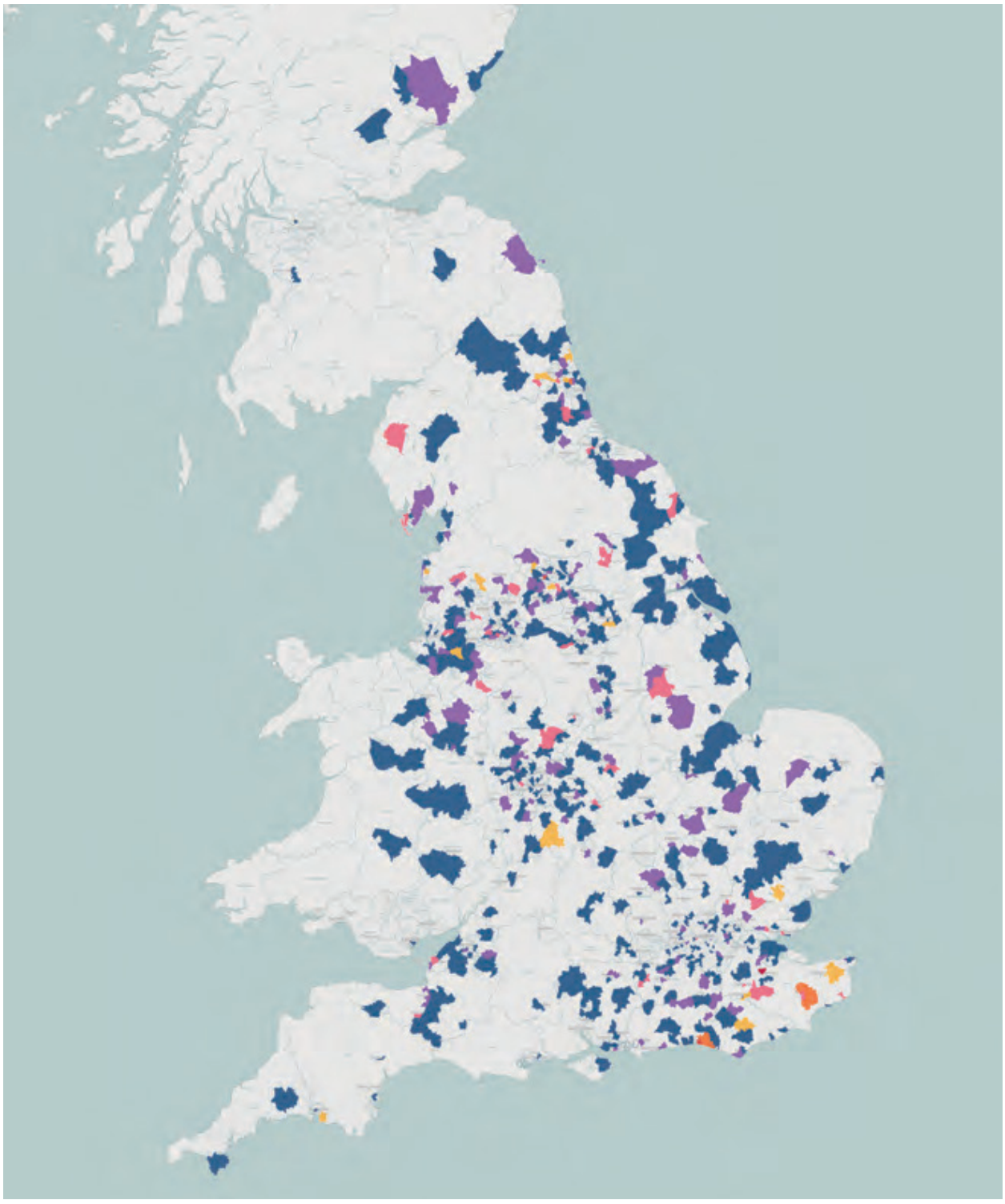
The TIDieR checklist (Table 7.2) is an extension of the CONSORT (CONsolidated Standards of Reporting Trials) 2010 statement that was developed to help overcome the inadequate reporting of interventions **(MOHER ET AL, 2010)**. The checklist was originally used predominantly to standardise the way that interventions were described in research protocols and RCTs. Cotterill et al (2018) used a typology of studies to classify how the TIDieR checklist had been used in applied health research at various stages of intervention analysis and development. The typology described 5 stages of research: 'Exploration (finding out what is going on), Explanation (explaining something new), Development (developing and implementing interventions), Feasibility in Context (implementation of an intervention previously developed somewhere else) and Exploitation (spread of an intervention into routine practice) **(COTTERILL ET AL, 2018 P.3 OF 10)**. The TIDieR checklist is used in this research to provide a systematic framework to both explain what is going on and to identify elements of intervention delivery that might be amenable to further adaptation and improvement.

Table 7.2. The TIDieR checklist (HOFFMAN ET AL 2014).

ITEMS

1. Brief name. Provide the name or phrase that describes the intervention.
2. Why: Rationale, theory or goal of the elements essential to the intervention.
3. What (materials): Physical or informational materials used in the intervention, including those provided to participants or used in intervention delivery or in training of intervention providers.
4. What (procedures): Describe each of the procedures, activities, and/or processes used in the intervention, including any enabling or support activities.
5. Who provided: For each category of intervention provider (for example psychologist, nursing assistant) describe their expertise, background and any specific training given.
6. How: Describe the modes of delivery (such as face to face or by some others mechanism such as internet or telephone) of the intervention and whether it was provided individually or in a group.
7. Where: Describe the type(s) of location(s) where the intervention occurred, including any necessary infrastructure or relevant features.
8. When and how much: Describe the number of times the intervention was delivered and over what period of time including the number of sessions, their schedule and their duration, intensity and dose.
9. Tailoring: If the intervention was planned to be personalised, titrated or adapted, then describe what, why, when and how.
10. Modifications: If the intervention was modified during the course of the study describe the change (what, why, when and how).
11. How well (planned): If intervention adherence or fidelity was assessed describe how and by whom, and if any strategies were used to maintain or improve fidelity, describe them.
12. How well (actual): If intervention fidelity was assessed, describe the extent to which the intervention was delivered as planned.

FIG 7.1. DISTRIBUTION OF RESPONDENTS WHO ENTERED THEIR WORK POSTCODE (N=998)



1 2 3 4 5 6 7 KEY: NO. OF RESPONDENTS FOR EACH POSTCODE

NB A LARGER SHADED AREA OF A UNIFORM COLOUR
MIGHT INDICATE AN AREA COVERED BY MORE THAN ONE POSTCODE.

7.4. Results

7.4.1 The sample

The survey was completed by 1599 of the 9,474 potential respondents. This represents 17% of the members and champions of the IHV and 14% of the estimated FTE HV workforce for England at the time of the survey (n=11,068 - **NHS DIGITAL 2017A**). Comparisons between the respondents and the national workforce need to be interpreted with caution as survey respondents are not all full-time and work in other parts of the UK besides England. The estimated national HV workforce may not be accurate because of the numbers of non-NHS organisations employing HVs (post Oct 2015) who are not required to submit workforce figures to NHS Digital (personal communication from workforce analyst – NHS Digital 2017b).

7.4.1.1. The respondents

Sociodemographic data was limited to location, experience and education.

7.4.1.2. LOCATION

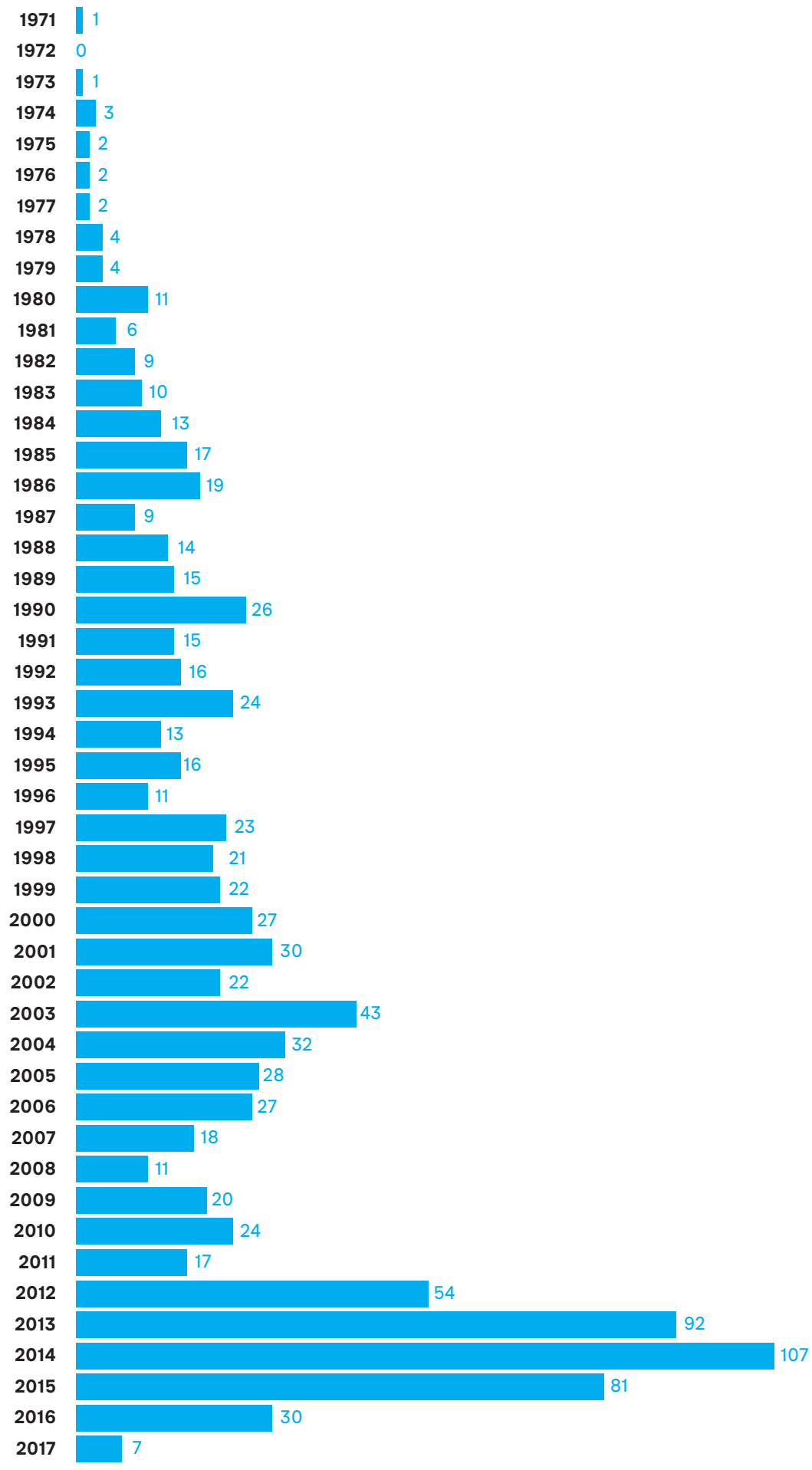
Respondents' work postcodes imported into a map created by Tableau software indicate a broad distribution of respondents from across the UK. (Fig 7.1).

7.4.1.3. EXPERIENCE

Respondents received their HV qualification between 1971 and 2017. Thirty nine percent (388/999) of the respondents qualified between 2011 and 2015 with the largest number (10% of the respondents) qualifying in 2014 (see Fig 7.2). The increase in the number of HVs qualifying between 2011 and 2015 corresponds to the period of the HV implementation plan **(DH, 2011A)**, that included a commitment to increase the number of HVs by 50% by 2015.

The average number of years that respondents had worked as a health visitor was 11.45 (n= 1108, range 0 – 45 years, standard deviation 10.48).

FIG 7.2. YEAR OF QUALIFICATION OF RESPONDENTS (N=999)



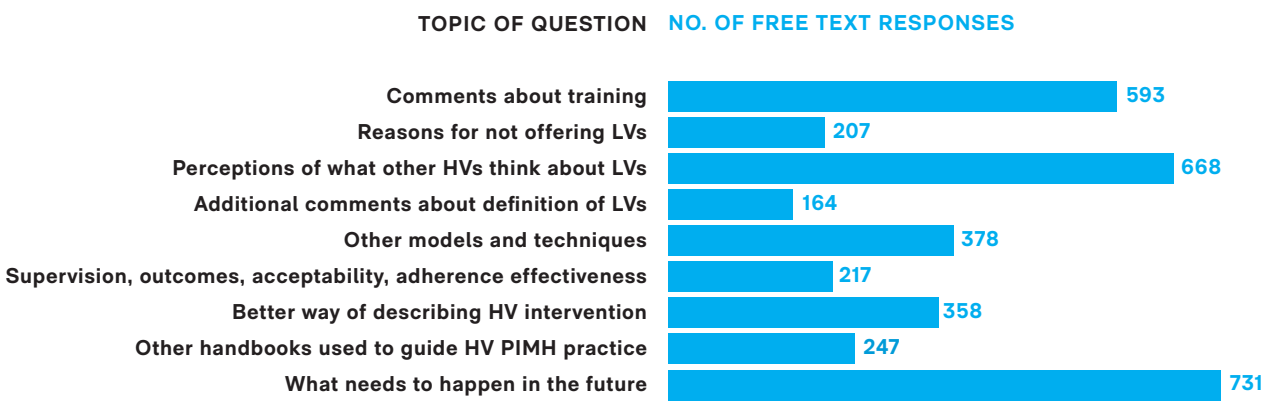
7.4.1.4. EDUCATION

Respondents were asked to list any additional qualifications they held, especially those that might indicate enhanced expertise in maternal mental health. It is assumed that community practice teachers (CPTs) with a responsibility to 'embed theoretical learning into practical expertise' and role-model how evidence-based practice is adapted to the specific culture and demands of the workplace environment **(HEE, 2014. P.6)** will also have advanced skills and knowledge. Twenty-one percent of the respondents were CPTs with a further 22% indicating that they held additional specialist qualifications relevant to their role in supporting mothers with MHPs. Additional qualifications included: psychotherapy, systemic family therapy, counselling, maternal and infant mental health, psychological therapies, CBT, mindfulness, Neurolinguistic Programming (NLP), solution focused therapy, therapeutic group work, art therapy, baby massage, mellow parenting, video interaction guidance, infant observation and assessment using the Brazelton neonatal assessment scale/neonatal behavioural observation. Seven percent of respondents were registered mental health nurses.

7.4.2. The Responses

Two thousand and thirty HVs started the survey. Responses could only be included if the respondents 'consented' to participate *and* pressed the 'submit' button at the end of the survey. The number of respondents who completed both these actions (or submitted a completed consent form with a survey returned by post) was 1599.The response rate to the 40 questions declined as the survey progressed. The mean number of respondents per question was 1,283. The total number of respondents to each question is included where appropriate (n). Between 10 and 46% of respondents provided free text responses to the open-ended questions contributing a total of 3,563 responses (104,249 words) (Fig 7.3). These responses were subject to contemporaneous deductive and inductive analysis. The Theoretical Domains Framework (TDF) was used for the deductive analysis. Inductive analysis was undertaken to ensure that no key issues were missed because they could not be allocated to a TDF domain. The responses allocated to the TDF domain 'nature of the behaviour' were subsequently coded according to the 12 items in the TIDieR checklist. As some items could be allocated to more than one domain of the TDF, the results are presented according to the most relevant domains that help to expose the salient findings.

FIG 7.3 RESPONSES TO OPEN-ENDED QUESTIONS



7.4.3. Survey findings

Descriptive statistics are integrated with the qualitative analysis of the free text comments and presented in relation to the domains of the TDF, to illustrate how the findings fulfil the objectives of the survey.

7.4.3.1. OBJECTIVE: TO ASCERTAIN WHETHER HVS BELIEVE THAT SUPPORTING MOTHERS WITH MHPS SHOULD BE AN INTEGRAL PART OF THEIR ROLE.

TDF Domains: Social/professional role and identity and social Influences

The TDF domains social/professional role and identity and social influences emphasise the importance of exploring individual perceptions and beliefs about whether mental health falls within the professional remit of health visiting, as well as what other health visitors think and do (subjective norms/social influences). The analysis starts with this domain because if HVs do not think that they should be supporting mothers with MHPs, this will influence their participation in the survey and/or their responses to the remaining questions.

Ninety-six percent (1502/1564) of respondents agreed that supporting mothers with MHPs should be an integral component of HV practice (Table 7.3a) with 95% (1474/1543) of respondents confident/very confident that other HVs (where they worked) shared this view (Table 7.4). Eighty-nine percent (1380/1550) of respondents agreed/strongly agreed that it was feasible to provide this support (Tables 7.3a).

Some respondents suggested that assessing mental health and delivering psychological interventions was not compatible with the public health role of the health visitor.

> *'I don't feel my role is to support mothers with mental health problems. My role is to prevent problems occurring and to identify problems early to ensure prompt, appropriate action.'*

The opposite view was also proposed, as assessing and responding to family health needs (including mental health) was cited as one of the fundamental principles of HV practice.

> *'HVs are already allocated to this family and are able to respond immediately to offer one to one support. If specialized mental health support is required, the HV is in a position to refer but offer support in the interim. HVs are also able to undertake low level intervention and hopefully prevent escalation of the clients emotional/mental health issues reducing referrals needed to mental health services.'*

Ninety-three percent (1161/1254) of respondents agreed that all HVs should assess and support mothers with MHPs (Table 7.3b). The belief, held by 84% (1044/1254) of the respondents, that HVs did not need to be a trained mental health professional (Table 7.3b) to be able to support mothers with MHPs attests to the undercurrent of dissent that was reflected in some of the free text responses. HVs who were trained mental health professionals were concerned that HVs without appropriate training might not be able to monitor changes in mental health presentations, assess risk, provide appropriate interventions, or appreciate the importance and parameters of a therapeutic contract.

> *'As an RMN I am completely comfortable with this aspect of practice in principle. What concerns me is that assessment of risk and severity of symptoms cannot be achieved by 'listening' alone.'*

'I am worried that sometimes HVs 'dabble' with offering this support because, either they like to, or they think they should, but they don't have the right training to do it properly... I feel that it should be acknowledged that expertise in mental health will not be an area of HV practice that everyone will have confidence in delivering and it should not be regarded as an integral part of our role.'

As LVs is the focal point of the research, it was essential to find out whether HVs were offering LVs to mothers with MHPs and whether individual HVs thought that all HVs were delivering them. Eight-five percent (1112/1550) of respondents were delivering LVs with 56% (709/1275) agreeing that most of the HVs in their organisation were offering LVs (Table 7.3a).

TABLE 7.3A. SURVEY RESPONSES: THE ROLE OF THE HV (1 OF 2)

SURVEY QUESTION	YES n(%)	NO n(%)	NOT SURE/DON'T KNOW n(%)
Q.2. Do YOU think that supporting mothers with mental health problems should be a core component of the work that health visitors do? (n=1564)	1502(96)	19(1)	43(3)
Q.3. Do you think it is feasible to expect health visitors to be able to identify and support mothers with mental health problems? (n=1550)	1380(89)	50(3)	120(8)
Q.15. Do you currently offer 'listening visits' to mothers with mild to moderate mental health problems? (n=1312)	1112(85)	55(4)	Offer support but not LVs 145(11)
Q.19. Do most of the health visitors in your organisation offer 'listening visits' as a therapeutic option to mothers identified with mild to moderate depression? (n=1275)	709(56)	112 (9)	353(28) Offer support but not LVs 101(7)

TABLE 7.3B. SURVEY RESPONSES: THE ROLE OF THE HV (2 OF 2)

SURVEY STATEMENT	STRONGLY DISAGREE n(%)	DISAGREE n(%)	NEITHER AGREE OR DISAGREE n(%)	AGREE n(%)	STRONGLY AGREE n(%)
Q.20. All health visitors should assess and support mothers with mental health problems (n=1254)	15(1)	28(2)	50(4)	402(32)	759(61)
Q.20. Health visitors are not mental health professionals and therefore should NOT be supporting women with mental health problems (n=1254)	447(36)	597(48)	154(12)	42(3)	14(1)

7.4.3.2. OBJECTIVE: TO EXPLORE THE FACTORS THAT MIGHT ENHANCE OR COMPROMISE THE CAPACITY OF HVS TO IDENTIFY AND SUPPORT MOTHERS WITH MHPS

TDF domain: Environmental context and resources

This domain refers to any circumstance or aspect of the healthcare environment that encourages or discourages the development and application of the requisite skills and abilities to enable enactment of the desired behaviour/delivery of the specified intervention **(ATKINS ET AL, 2017)**.

HVs may be limited in their ability to provide perinatal mental health assessment and care if their professional remit is not understood by others. Health visiting practice is dictated by commissioning priorities and facilitated by managerial support. HV perceptions of the attitudes of these key personnel provides an indication of how well funded and supported HV's feel in this aspect of their role. Seventy-five percent (1162/1547) of respondents were confident that their managers thought that supporting mothers with MHPs was an integral component of their practice with 27% (420/1547) of respondents confident that commissioners shared this view (Table 7.4).

The negative perceptions of commissioners may be a consequence of the organisational restructuring that involved the transfer of the commissioning and funding of health visiting services to Local Authorities (LA) in October 2015. Concomitant cuts in LA public health budgets required commissioners to make difficult decisions about how to spend their allocated funds. In many cases this involved reductions in the HV workforce and/or restrictions to their scope of practice.

> *'We would all love to be able to support mothers far more than staffing levels and therefore available time and resources allow. It is highly frustrating and demoralizing.'*

> *'LVs are not a priority and HVs will not be able to offer them in this area in the future due to high caseloads/work commitments and low staffing numbers.'*

Concerns were expressed that even the 5 mandated contacts that should be offered to all families by HVs were no longer being commissioned. Some respondents had been advised that they could only offer LVs if they had the time and if they had achieved their required number of contacts according to predetermined key performance indicators (KPIs). Many respondents felt that they were overburdened by a target-driven culture that failed to measure the things that really mattered and compromised the professional autonomy of HVs.

> *'The pressure of time is increasingly a threat to quality listening visits as the organization continually and frequently changes the goal posts adding to the workload and responsibilities of HVs so HVs don't even know what they should be doing any more.'*

Some respondents felt that the diminishing workforce meant that HVs did not have sufficient opportunities for developing a relationship with families that would facilitate disclosure of MHPs, even though HVs were potentially in an ideal position to provide appropriate support. Others highlighted competing priorities such as dealing with safeguarding concerns or responding to the complex needs of fractured families facing fuel, financial and food poverty, as negative influences on capacity to deal with MHPs.

> *'LVs are the first thing to go when safeguarding issues arise but as a staff group we recognize the significance of meeting the mental health needs of the mother to improve the outcomes for the child.'*

> *'When the team is struggling to achieve even new births it is hard to justify listening visits to colleagues. This puts pressure on you to decide which Mums are more depressed than others.'*

TABLE 7.4. SURVEY RESPONSES: THE VIEWS OF OTHERS

SURVEY QUESTION	NOT CONFIDENT AT ALL n(%)	NOT CONFIDENT n(%)	NEUTRAL n(%)	CONFIDENT n(%)	VERY CONFIDENT n(%)
Q.1. How confident are you that the majority of the following people where you work think that supporting mothers with MHPs should be a core component of HV practice?					
LA Commissioners (n=1547)	217(14)	488(32)	422(27)	299(19)	121(8)
Managers of HV service (n=1533)	40(3)	136(9)	195(13)	713(46)	449(29)
Health visitors (n=1543)	9(1)	22(2)	38(3)	365(23)	1109(71)

A surrogate measure of the priority accorded by commissioners/managers to HV perinatal mental health practice is reflected in HV expectations of being able to offer assessments of maternal mental health on the two postnatal occasions recommended in the national health visiting core service specification 2015/16 **(NHS ENGLAND, 2014)**. Although 90% (1398/1555) of respondents were confident/very confident that HVs in their organization were offering a 6-8-week maternal mental health assessment, only 30% (456/1528) were confident/very confident that a 3-4-month maternal mental health assessment was universally offered (Table 7.5.)

TABLE 7.5. SURVEY RESPONSES: EXPECTATIONS OF COMPLIANCE WITH THE 2015/16 CORE HEALTH VISITING SERVICE SPECIFICATION

SURVEY QUESTION	NOT CONFIDENT AT ALL n(%)	NOT CONFIDENT n(%)	NEUTRAL n(%)	CONFIDENT n(%)	VERY CONFIDENT n(%)
Q.4. How confident are you that the majority of the health visitors in your organisation are assessing maternal mental health at these times?					
6-8 weeks (n=1555)	25(2)	63(4)	69(4)	525(34)	873(56)
3-4 months (n=1528)	532(35)	387(25)	153(10)	243(16)	213(14)

Some of the free text responses indicated that cuts in public health budgets were imposing limitations on HV capacity to offer either of these assessments to all mothers or to offer LVs to all mothers who needed them. These comments reflected the quantitative data suggesting that 30% (380/1278) of respondents felt that they did not have enough time to deliver the number of LVs that they thought were necessary and 48% (616/1274) of respondents agreeing or strongly agreeing that they were not able to offer LVs to every women whom they thought needed them (Table 7.6).

> *'Our trust does not have health visiting capacity for 6-8 week or 3-4-month mental health assessments so unless identified as at risk at the new birth visit, or in the clinic, further assessments are not undertaken.*

> *'I think it is ridiculous to assess mental health at the 6-8 week check and then not be able to reassess at later date. Although it is in the health visiting spec to visit at 3-4 months, again it is not one of our mandated visits by our local authority. There is also no time or suitable place to ask about mental health at the 9 month development review. So really if a mother develops depression after 8 weeks of having a baby they are on their own.'*

> *'Capacity and caseload numbers make it very difficult to know who is on your caseload, who needs support and fitting in weekly visits.'*

> *'I have received excellent training in a variety of styles during the course of my career and feel they are very beneficial to mothers I have identified as needing this intervention. However I no longer have the capacity within my working hours to offer them as I would like which undervalues my skills and the excellent training I have received to undertake them.'*

TABLE 7.6. SURVEY RESPONSES: LIMITATIONS ON HV CAPACITY TO PROVIDE LVS

STATEMENT	STRONGLY DISAGREE n(%)	DISAGREE n(%)	NEITHER AGREE OR DISAGREE n(%)	AGREE n(%)	STRONGLY AGREE n(%)
Q.18. I have enough time to deliver the number of 'listening visits' I think are necessary. (n=1278)	207(16)	463(36)	228(18)	304(24)	76(6)
Q.18. I am able to offer 'listening visits' to every woman whom I think needs them. (n=1274)	130(10)	329(26)	199(16)	477(37)	139(11)

Comments were also made that without the opportunity to develop and hone competence in perinatal mental healthcare that HV's would eventually become de-skilled in this aspect of practice.

> *'We do not have enough time to offer this service. We work to a tight core service in our Trust and although in theory we offer an enhanced service to clients with mental health problems, in practice we are not able to offer more than minimal support and over time our skills are diminishing.'*

> *'I do offer 'listening visits' but have little capacity to provide what I consider would be valuable. As the HV service in our area has been poor for many years mothers' understanding of our service is low and they do not expect to get support from HVs and look elsewhere.'*

Aspects of context include policies, protocols, pathways, guidance and mechanisms for recording and retrieving healthcare outcomes. Seventy-nine percent (1380/1550) of respondents thought that their organisation had a protocol, policy or pathway that specified what actions HVs should take, and the sort of support HVs should provide, when they identify mothers with MHPs (Table 7.7). The finding that only 55% (654/1181) of respondents thought that there was agreement within their organisation regarding the structure and duration of the intervention that HVs offered to mothers with MHPs implies that the protocol or policy may not have been adhered to. This was borne out by some of the free text comments, such as:

> *'I feel practitioners have different ideas on 'who', 'when' and 'how' LVs should be offered. My experience of working with different teams and team members suggests the guidance may be disregarded.'*

The amount of support that was provided by HVs was also influenced by the availability of other services. Respondents expressed concern that pathways had been devised that were impossible to follow and did not meet the needs of mothers and their families. For example, HVs were expected to refer mothers with MHPs to other services such as GPs and primary and secondary mental health services but respondents stated that mothers did not meet eligibility criteria; did not necessarily want this kind of support; found it hard to access services that required transport or where it was not acceptable to take the baby; or the services that were offered did not meet their needs.

> *'Women are assessed and assessed again by single point of access team but little therapy offered as a result of such assessments!*

> *'I refer clients to 'talking Therapies', which unfortunately are a one-off consultation and self-help groups. Not useful for women who are finding it hard to go out or indeed to talk.'*

> *'The onward referral process to mental health services, GPs and other therapeutic mental services including self-help is vague. The escalation in severe cases is also vague.'*

HVs commented that cuts in funding to mental health services led to long waiting lists, compromised collaborative care and lack of personnel for HVs to consult with regarding clients they were 'holding' who really needed treatment and support from mental health teams. The lack of accessibility or availability of other services meant that HVs were often required to practice beyond the limits of their competence by trying to support mothers who needed more specialist services.

> *'Although we are not mental health professionals having discussed and assessed a woman's mental health myself and (I think) my colleagues feel that we have a duty of care to support. It can take time for women to access the other support available such as counselling and CBT which are commissioned by the local CCG and I feel that we offer crucial support when there is no other support yet available or to women who require help to access that support at a crucial period for infant mental health and brain development.'*

The NICE guideline recommends that health professionals delivering psychological or psychosocial interventions should have a manual to guide their practice **(NICE 2014A)**. Twenty percent (240/1190) of respondents reported having access to a manual, with 95% (228/240) of those who had a manual reporting that they found it helpful. Seventy-six percent (828/1089) of those who did not have a manual would like one. In response to a further question exploring preferred opportunities for learning, 72% (904/1251) said that having a manual represented their preferred method of learning about LVs.

TABLE 7.7. SURVEY RESPONSES: ORGANISATIONAL COMMITMENT AND INFRASTRUCTURE

SURVEY QUESTION	YES n(%)	NO n(%)	NOT SURE/ DON'T KNOW n(%)
Q.5. Does your organisation have a protocol, policy or pathway in place that specifies what actions health visitors should take, and the sort of support health visitors should offer to women, when they identify mothers with mental health problems? (n=1534)	1212(79)	142(9)	181(12)
Q.24. Would you say that there was agreement within your organisation regarding the structure and duration of the intervention that health visitors offer to women with mental health problems? (n=1181)	654(55)	386(33)	141(12)
Q.24. Do you have a handbook/manual/guidance that informs your practice with respect to the structure and duration of the intervention that you offer to mothers with mental health problems? (n=1190)	240(20)	753(63)	197(17)
If you have a handbook/manual/guidance – do you find it helpful? (n=240)	228 (95)	12 (5)	0
If you do not have a handbook/manual/guidance – would you like one? (n=1089)	828 (76)	56 (5)	205 (19)

Some respondents indicated that they felt well supported by their peers, had access to regular supervision and had a clear and shared understanding of the purpose, content and expected outcomes of the intervention they were offering. Many more respondents felt anxious, unsupported, uncomfortable and overwhelmed due to lack of training, supervision and support.

'Competence is defined in the context of particular knowledge, traits, skills, and abilities' **(KAK ET AL, 2001 P.2.)** and develops as a result of training, experience and access to a more knowledgeable other. Competence is needed but does not guarantee optimal performance. Both individual and organizational factors influence competent, confident practice. One of those factors is the availability and quality of training.

Fifty-five percent (761/1384) of respondents had received training in how 'to do' LVs (34% had not received training, 11% were not sure). Twenty-seven percent (352/1322) of respondents felt that they had received sufficient training in how to do LVs. (47% said that they had not, 26% were not sure). (Table 7.8). It is not surprising that some of the respondents who had received little or no training in what to do in LVs were reluctant to deliver them.

Some respondents highlighted the excellent training that they had received but were unable to apply their training in practice due to staff shortages, large caseloads, safeguarding responsibilities and the need to deliver on commissioned mandated contacts.

In order to gain a sense of whether the predominant method of learning was classroom or practice-based or a combination of the two, respondents were invited to specify the accessed and preferred format of opportunities to learn about LVs (Table 7.9, Fig 7.4).

The greatest percentage of respondents indicated that they learnt about LVs by accompanying another HV on a LV (56%), with role playing (49%) or watching role plays (48%), or video clips of LVs (42%), the next most frequently cited learning opportunities. With regard to preferred ways of learning about LVs over 60% of respondents wanted a series of lectures/workshops (67%), regular training updates (70%) and a manual/handbook on how to deliver LVs (72%).

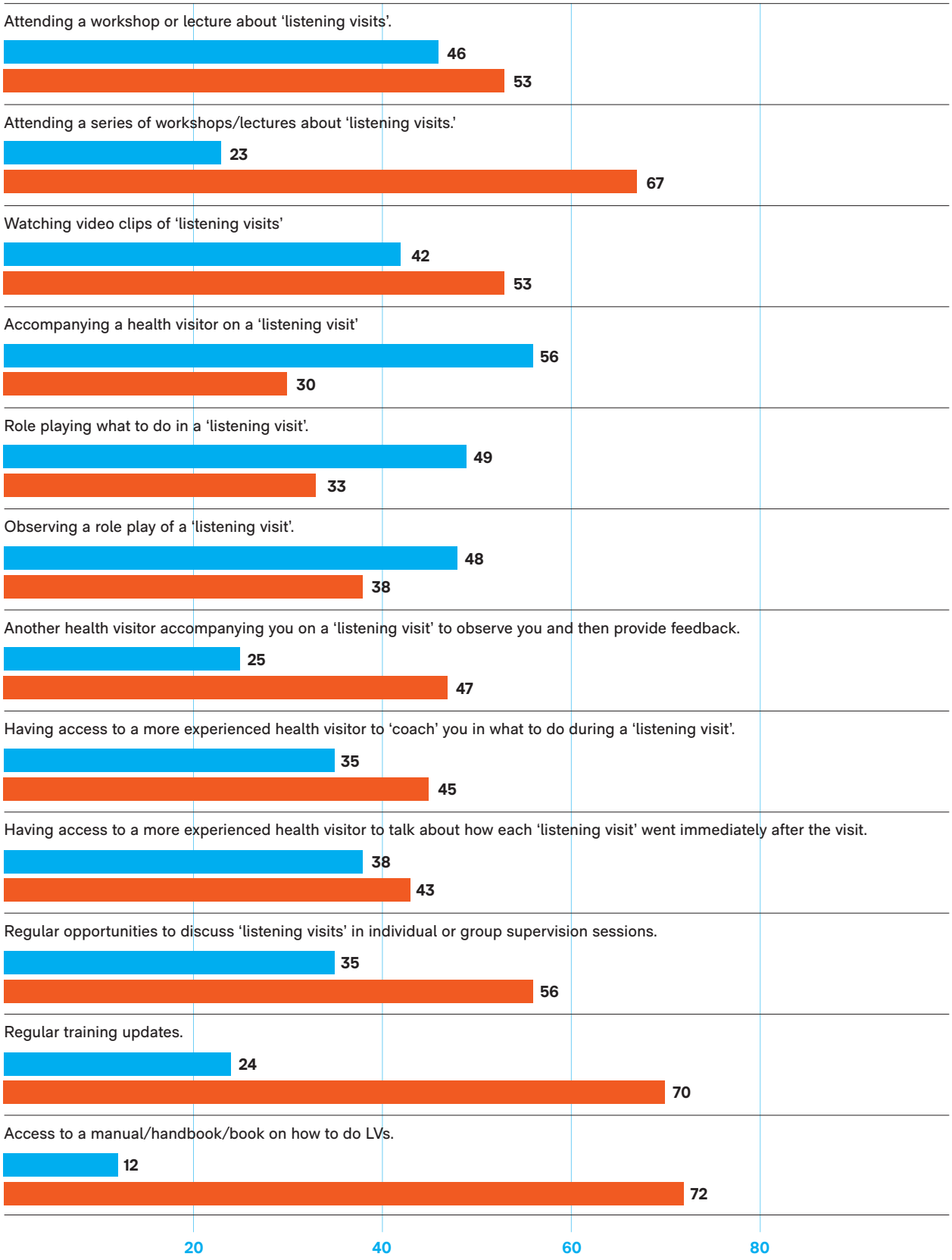
TABLE 7.8. SURVEY RESPONSES: TRAINING IN LVS

SURVEY QUESTION	YES	NO	DON'T KNOW/ NOT SURE
Q.11. During any of the perinatal mental health training that you have attended, have you received training in how to do 'listening visits?' (n=1384	761(55)	473(34)	150 (11)
Q.14. Do you think you have received sufficient training in how to deliver 'listening visits?' (n=1322)	352(27)	643(47)	327(26)

TABLE 7.9. SURVEY RESPONSES: ACCESSED AND PREFERRED FORMATS OF OPPORTUNITIES FOR LEARNING ABOUT LVS (N=1251)

SURVEY QUESTION		
Q.12. When you were learning how to do 'listening visits' did you have the opportunity to learn how to do them in any of the following ways? Would you have liked to have had the opportunity to access any of these ways of learning? Please tick all that apply	I had the opportunity to learn about LVs in this way	I would have liked the opportunity to learn about LVs in this way
Attending a workshop or lecture about 'listening visits'.	582 (46)	669 (53)
Attending a series of workshops/lectures about 'listening visits.'	277 (23)	843 (67)
Watching video clips of 'listening visits'	523(42)	657(53)
Accompanying a health visitor on a 'listening visit'	707(56)	374(30)
Role playing what to do in a 'listening visit'.	618(49)	416(33)
Observing a role play of a 'listening visit'.	601(48)	476(38)
Another health visitor accompanying you on a 'listening visit' to observe you and then provide feedback.	308 (25)	591 (47)
Having access to a more experienced health visitor to 'coach' you in what to do during a 'listening visit'.	444(35)	559(45)
Having access to a more experienced health visitor to talk about how each 'listening visit' went immediately after the visit.	482 (38)	540(43)
Regular opportunities to discuss 'listening visits' in individual or group supervision sessions.	443(35)	698(56)
Regular training updates.	296(24)	875 (70)
Access to a manual/handbook/book on how to do 'listening visits'	156 (12)	904(72)

FIG 7.4. ACCESSED AND PREFERRED FORMATS OF OPPORTUNITIES FOR LEARNING ABOUT LVS (N=1251)



Nearly 600 free text comments were made about training in LVs. Some of these comments suggested a link between motivation, outcomes, a poorly articulated intervention and a lack of adequate training and support.

> *'You can't measure something that HVs have not been properly trained to do.'*

> *'We do not get any formal training and therefore feel unqualified to undertake listening visits. I have heard colleagues saying, '"Don't ask, so you don't have to deal with the consequences of asking."'*

> *'The training is minimal and therefore everybody approaches them differently or is afraid of them so don't really offer them.'*

> *'All training is only as good as the ongoing support as people frequently start with good intentions, but without regular space for reflection and robust support from organisations, practices such as 'listening visits' quietly die away.'*

Training on its own will not ensure competent, confident, consistent practice. Meverach (1995) suggests that practitioners implementing new ways of working go through a 'survival' phase wherein they question the new techniques, feel ambivalent about their use and experience a disruption in their existing knowledge. During this phase even experienced practitioners may be inflexible and mechanical in their practice and depend on consultants for advice. The displacement of habitual practice with new skills and techniques may lead to an initial decline in performance and outcomes. It is estimated that 20 – 25 implementation attempts are required to embed consistent changes in professional behavior **(JOYCE & SHOWERS, 2002)**. Continuing encouragement to hone skills, increase familiarity with interventions and overcome barriers to delivery is required to initiate, consolidate and sustain effective practice. Mechanisms such as 'coaching', action learning sets and restorative supervision help to ensure safe and optimal delivery of the intervention.

> *'Staff have differing amounts of experience and over time most have received training in lots of different areas e.g. mindfulness…but being able to incorporate it into practice is very difficult as I have always felt you are just touching the surface giving some skills, but not experience to follow practice up with theory and there is resistance by some HVs.'*

To give an indication of the degree of familiarity with the intervention respondents were asked to specify how many mothers with MHPs they had offered a package of support to over the preceding five years (question 17 in the survey). Forty-nine percent (635/1284) had provided support to 20 or less mothers with MHPs during this time frame equating to an average of 4 packages of perinatal mental health support delivered/respondent/year. Twenty-nine percent (377/1284) had supported 30+ mothers over the five-year time frame. It is difficult to draw any specific conclusions from this finding as it is not known what each package of care involved in terms of skills required, type of support provided, or number of sessions delivered. It is possible that the limited number of mothers seen indicate insufficient opportunities to consolidate practice; anxiety about, or avoidance of, delivering the intervention; or reflect contextual factors that limit the capacity of HVs to identify or support all mothers with mild to moderate MHPs.

TDF Domain: Behavioural Regulation

Behavioural regulation refers to any mechanism that aims to manage or change objectively observed or measured actions with a view to providing an enabling environment to ensure that interventions/ actions are delivered with consistency and fidelity **(LIPWORTH ET AL, 2013)**. The NICE guideline **(NICE, 2014A)** states that systems should be in place to monitor practitioner competence and adherence to treatment. Perceptions of these issues were explored. Nineteen percent (221/1160) of respondents were confident/very confident that all HVs received regular high-quality supervision relating to the support they provided to mothers with MHPs. Eleven percent (130/1153) of respondents were confident/very confident that systems were in place to monitor HV competence with regard to their management of MHPs. Seventeen percent (198/1159) were confident/very confident that systems were in place to monitor and evaluate treatment adherence with regard to HV management of MHPs (Table 7.10).

TABLE 7.10. SURVEY RESPONSES: GOVERNANCE AND QUALITY ASSURANCE

SURVEY QUESTION

Q. 26. The NICE guideline for antenatal and postnatal mental health (December 2014) includes various statements about the delivery of interventions for mental health problems in pregnancy and the postnatal period (which are not necessarily called LVs) How confident are you that the following statements are true for the health visitors in your organisation?

	NOT CONFIDENT AT ALL n(%)	NOT CONFIDENT n(%)	NEUTRAL n(%)	CONFIDENT n(%)	VERY CONFIDENT n(%)
All health visitors receive regular high quality supervision relating to the support that they offer to women with mental health problems. (n=1160)	281(24)	448(39)	210(18)	184(16)	37(3)
All health visitors use routine outcome measures to assess the impact of any intervention they deliver to address maternal mental health issues. (n=1156)	147(13)	345(30)	268(23)	357(31)	39(3)
Health visitors involve women in reviewing the efficacy of any intervention they have delivered to address maternal mental health issues. (n=1157)	90(8)	235(20)	308(27)	467(40)	57(5)
Systems are in place to monitor and evaluate treatment adherence with regard to health visitor management of perinatal mental health problems. (n=1159)	190(16)	459(40)	312(27)	178(15)	20(2)
Systems are in place to monitor health visitor competence with regard to their management of perinatal mental health problems. (n=1153)	241(21)	513(45)	269(23)	117(10)	13(1)

Effective delivery of health care interventions relies on the capacity, confidence and competence of the workforce **(BLAIR, 2019)**. Capacity is influenced by both extrinsic features of the environment (TDF domain: environmental context and resources) and intrinsic personal qualities and characteristics (such as those encompassed by the TDF domains emotion; motivation and goals; beliefs about capabilities; beliefs about consequences). These domains are considered in the following sections demonstrating the inter-relatedness of the different domains of the TDF. Capacity, confidence and competence also rely on the acquisition of relevant knowledge and skills. The survey findings relating to this domain are presented in section 7.4.3.3. as this section demonstrates how the findings relate to the third objective of the survey: to determine whether HVs believe that they have the necessary knowledge and skills to support mothers with MHPs.

TDF Domain: emotion

Confidence is compromised by anxiety about adequate performance that may arise from personality traits, inadequate preparation, insufficient practice or contextual factors inhibiting optimal delivery. Practitioners who do not know what is expected of them have to invest extra effort in clarifying the ambiguities of their role but also, if they don't know what they are supposed to be doing, are less motivated and perform less effectively. Role ambiguity, alongside unfair treatment at work, unmanageable workload, unreasonable time pressure, and lack of communication and support from a manager were the five factors most highly correlated with emotional burn-out in a Gallup poll of 7,500 employees in 2018 **(WIGERT & AGRAWAL, 2018)**. Many of these factors have been mentioned by survey respondents.

The additional stress experienced by HVs may be partially explained by the decline in the HV workforce. The number of full-time equivalent HVs steadily declined from 10,309 at the end of the HV implementation plan in March 2015 to 7,852 by July 2018 **(IHV, 2018)**. In the state of health visiting survey published in 2018, stress levels amongst HVs had increased, mainly because of long hours and concerns about the safety and unmet needs of vulnerable clients (iHV, 2018). These findings from the 2018 iHV survey echo the comments made by HVs to this 2016 survey. Respondents in this survey reported feeling stressed, frustrated, demoralised and overwhelmed by staff reductions; excessive workloads; compromised autonomy; safeguarding priorities; managerial insensitivities; a 'tick-box' culture; covering vacant school nurse caseloads; and pressure to deliver on key performance indicators (related to mandated contacts) leaving insufficient time available to provide responsive support to families with additional needs.

> *'HVs want to support mothers but they often feel ill-equipped and the visits are probably not as effective as they could be given specific training.'*

> *'Staff shortages and excessive workloads have led to HVs avoiding scratching the surface for fear of becoming overwhelmed.'*

It can be mentally demanding working with individuals with MHPs in terms of emotional contagion, the potential resonance of maternal psychological distress with the lived experience of the HV and the potentially anxiety-invoking imperative to respond sensitively and appropriately to unexpected disclosure of serious or life-threatening symptoms. Some respondents highlighted the emotional toll experienced by HVs trying to cope with the complexity and uncertainty of how to respond appropriately to the mental health needs of mothers, or the frustration arising from the lack of capacity to provide the support that they thought was needed.

> *'I don't feel confident that I have received adequate training to offer established techniques so I rely on drawing on personal experience of dealing with life situations instead and I am not at all confident that this is a safe approach, especially at times when I feel that my own mental state is not strong.'*

> *'Every LV is different and can demand different skills. I find them exhausting and draining, especially as waiting lists for mental health services are so long.'*

> *'Personally, I find them difficult to do because I often feel I have 'soaked up' the client's emotional pain, so I feel drained and exhausted afterwards. But I feel they are a vital part of our job.'*

> *'Newly qualified health visitors are very scared of completing LVs, due to poor training and lacking confidence.'*

It should also be noted that positive experiences were reported when HVs perceived that they had access to excellent training, nurturing managers and restorative support.

TDF Domain: Motivation and goals

Motivation is defined as 'all those brain processes that energise and direct behaviour, not just goals and conscious decision-making' **(MICHIE ET AL, 2011, P.4)**. Motivation is influenced by the perceived importance of the behaviour and confidence in performing the behaviour. According to the COM-B (capability, opportunity, motivation, behaviour) model of behaviour, that is regarded as a summary version of the TDF, capability and opportunity are the precursors of motivation **(MICHIE ET AL, 2011)**. If an individual does not think that they are capable of carrying out a required behaviour and the environment is not conducive to the enactment of the behaviour, motivation is undermined.

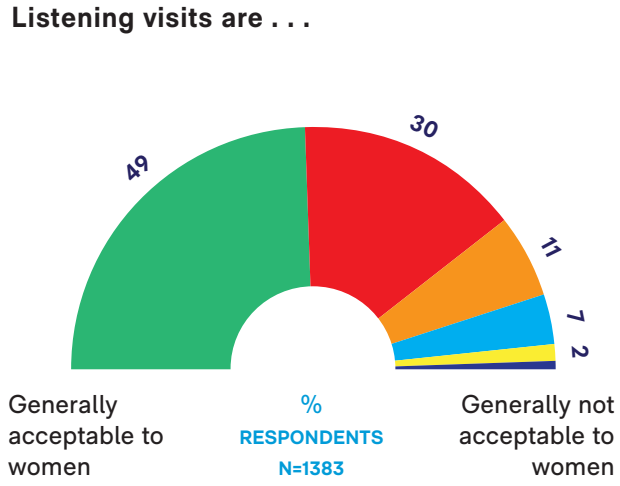
It is apparent from some of the responses that it is hard to remain motivated when commissioners and managers do not recognise and value the work that is being done; HVs are required to modify the intervention in ways that are unacceptable to them because they believe the modifications compromise effectiveness; it feels as though there is nobody else to share the burden of support; or HVs believe that the support that is available is not responsive to the needs of mothers.

> *'I think current staff shortages and increased travel times have impacted on the capacity of HVs to respond with LVs, which is causing many staff to leave the service as having assessed a client and identified a need it does not feel professional or ethical not to offer further support and referring to a specialist service can mean a wait for the mother.'*

Motivation depends on the attitudes of individual HVs regarding the appropriateness, ease of delivery and anticipated benefits of LVs. Attitude is a positive or negative response to a particular issue **(FISHBEIN & AJZEN, 1975)**. Semantic differential questions (question 10 in the survey), using bipolar adjectives, were deployed to ascertain the attitudes of the respondents. Responses were recorded on a 7-point continuum between two extremes.

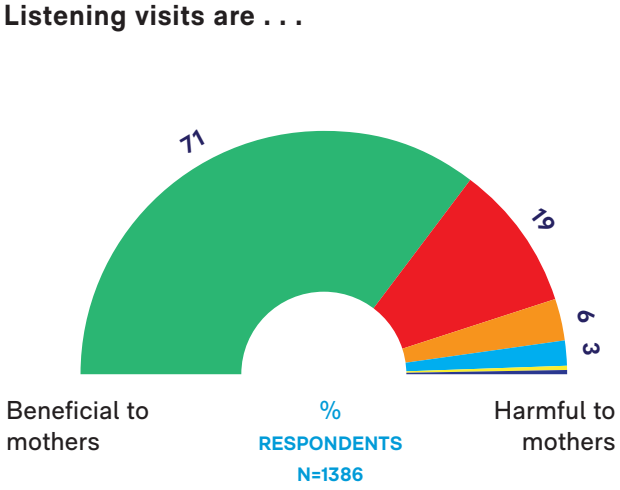
As an indication of appropriateness, respondents were asked to consider whether they thought that LVs were acceptable and beneficial to mothers. Research has shown that professionals may choose not to offer an intervention because they think it will not be acceptable or beneficial to the recipient **(SEKHON ET AL, 2017)**. Ninety percent (1248/1383) of respondents ticked the 3 boxes on the acceptable end of the acceptable/not acceptable continuum.

FIG 7.5. SURVEY RESPONSES TO SEMANTIC DIFFERENTIAL QUESTION ABOUT HV PERCEPTIONS OF ACCEPTABILITY OF LVS TO WOMEN.



In the semantic differential question regarding perceptions of benefits/harms of LVs for mothers 96% (1338/1386) respondents ticked the boxes on the beneficial side of the continuum.

FIG 7.6. SURVEY RESPONSES TO SEMANTIC DIFFERENTIAL QUESTION ABOUT HV PERCEPTIONS OF BENEFITS/HARMS OF LVS TO WOMEN.

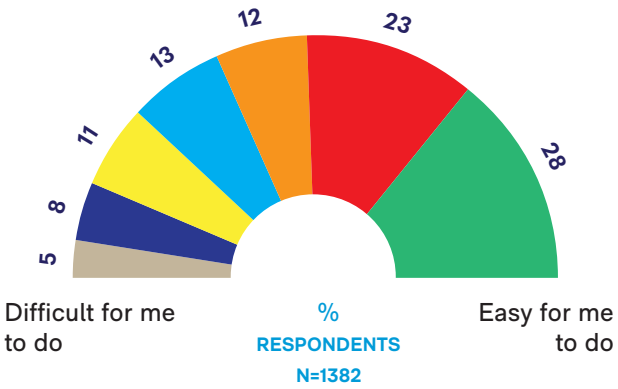


Some of the comments confirm that not all respondents perceive LVs as acceptable or beneficial to mothers.

> *'LVs are offered but I find that most women do not want them.'*
>
> *'My colleagues all agree that we are not sure how to carry out LVs in a way that benefits the clients.'*
>
> *'In contemporary therapeutic work, based on neurobiology etc, there is no place for the out-dated model of LVs. This is ineffective at best and harmful at worst in anxiety and depression as it invites the pathological, ruminatory thinking style that characterizes these disorders.'*

On the easy/difficult continuum, 63% (874/1382) of respondents indicated that they found LVs easy to do although 24% (325/1382) found them difficult to do.

FIG 7.7. SURVEY RESPONSES TO SEMANTIC DIFFERENTIAL QUESTION ABOUT HV PERCEPTIONS ABOUT HOW EASY OR DIFFICULT THEY FOUND DELIVERING LVS.

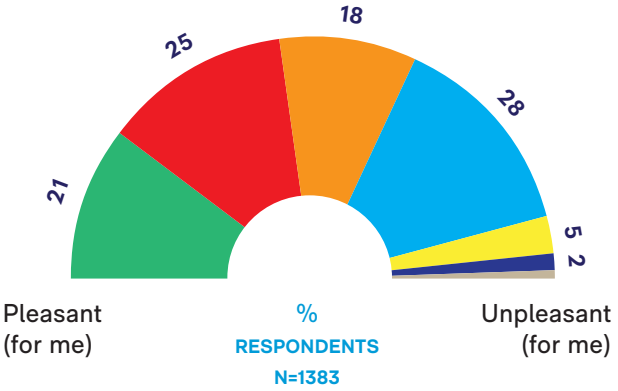


Some comments suggested that difficulties potentially arose from opening a 'Pandora's box' of issues that health visitors felt ill-equipped to deal with.

> *'I think LVs can reveal deep thoughts and feelings that might be outwith my skill base, I may make the wrong response – within the LV I have created this environment that encourages a woman to open up and verbalise her feelings – I am aware of my skill limitations and therefore more complex depression would require more specialist support.'*

Sixty-four percent (892/1382) respondents found LVs pleasant to do with 28% (380/1382) ticking the middle box to suggest that they were neither pleasant or unpleasant to do. In response to a subsequent question 82% (1046/1272) agreed/strongly agreed that delivering LVs was a rewarding part of their practice (Table 7.12).

FIG 7.8. SURVEY RESPONSES TO SEMANTIC DIFFERENTIAL QUESTION ABOUT HV PERCEPTIONS ABOUT HOW PLEASANT OR UNPLEASANT THEY FOUND DELIVERING LVS.



TDF Domain: Beliefs about capabilities

'Beliefs about capabilities' are relevant because the level of confidence an individual possesses about their ability to perform a particular behaviour is likely to affect whether or not they implement it' **(LIPWORTH ET AL, 2013 P.6)**. In order to perform the behaviour an individual has to believe that they know when to offer the intervention, that the intervention they are offering is the right thing to do, that they know what the intervention entails, and they are confident that it will be beneficial. Eighty-eight percent (1126/1283)of respondents agreed that they had a clear understanding about what is meant by LVs. Seventy-six percent (963/1277) agreed that they had the necessary knowledge and skills to deliver LVs safely and effectively. Seventy-seven percent (983/1278) of respondents agreed/strongly agreed that they felt confident in their ability to deliver LVs. Eighty percent (1026/1279) agreed/strongly agreed that they always offered LVs as an option to mothers identified with additional mental health needs. Seventy-one percent (906/1279) were confident that the support provided would lead to positive outcomes.

TABLE 7.11. SURVEY RESPONSES: HV CONFIDENCE IN DELIVERING LVS

STATEMENT	STRONGLY DISAGREE n(%)	DISAGREE n(%)	NEITHER AGREE OR DISAGREE n(%)	AGREE n(%)	STRONGLY AGREE n(%)
Q.18.I have a clear understanding of what is meant by LVs (n=1283)	16(1)	40(3)	101(8)	663(52)	463(36)
Q.18. I have the necessary knowledge and skills to deliver LVs safely and effectively (n=1277)	19(1)	84(7)	211(17)	643(50)	320(25)
Q.18. I feel confident in my ability to deliver LVs (n=1278)	20(2)	82(6)	193(15)	652(51)	331(26)
Q.18. When I identify a mother with additional mental health needs I always offer LVs as an option of support to the mother (n=1279)	30(2)	77(6)	146(11)	585(46)	441(34)
Q.18. I feel confident that the support I provide during the course of 'listening visits' will lead to improved outcomes for the women that I am supporting. (n=1279)	21(2)	61(5)	291(23)	639(50)	267(21)
Q.18. I find delivering 'listening visits' a rewarding part of my health visiting practice. (1272)	20(2)	30(2)	176(14)	551(43)	495(39)

TDF Domain: Beliefs about consequences

Interventions delivered by clinicians are expected to culminate in measurable beneficial health outcomes. Ninety-six percent of respondents indicated that they believed that LVs were beneficial, although it was not always possible to quantify the benefits that accrued.

> *'Often mothers have benefitted simply from the knowledge that they are an individual in whom it is worth investing time to listen.'*

> *'Working with mothers with poor mental health, as we know, is time consuming, the benefits, as we know, are enormous but measuring and payment for this type of work is difficult to prove to the organisation.'*

In response to subsequent questions 70% (836/1196) of respondents agreed/strongly agreed that LVs involved using evidence-based information to help mothers regain their self-management abilities when these have been adversely affected by mental distress. Seventy-one percent (906/1279) of respondents agreed/strongly agreed that the support provided during the course of LVs would lead to improved outcomes.

Many respondents asserted their beliefs that 'listening visits' were beneficial to mothers, fathers and babies although the benefits could not always be quantified and therefore it was difficult to provide evidence to HVs, and others, of the impact of HV perinatal mental health interventions.

According to the Donabedian model of healthcare, information about the quality of healthcare can be derived from three categories: structure, process and outcome. Structure relates to the context for delivery, process refers to what happens between the provider and recipient of care, and outcomes refer to the effects of healthcare on the patient **(DONABEDIAN, 1988)**.

The emphasis on process rather than outcomes is supported by the quantitative findings. Indications of assessment and engagement were more frequently recorded than outcomes (Table 7.8). Seventy-six percent (1157/1527) of respondents thought that there was a system for recording the number of women who have had their mental health assessed by a HV; 52% (786/1526) thought that there was a system for recording the number of women who received an intervention for their MHPs from a HV; 22% (339/1526) thought that there was a system for recording the number of women who no longer had a MHP at the end of an intervention from a HV (Table 7.12). One respondent implied, by her comment, that 'process' appears to be more important than 'outcome'.

> *'HVs are not encouraged to be outcomes focussed and to report on, and identify amongst themselves and to managers, the positive impact they can make on families' lives. In this way they can be focussed on just getting visits done rather than thinking about what they hope to achieve.'*

Eighty percent (959/1199) agreed/strongly agreed that at the end of 4-6 LVs an appropriate assessment tool is used to assess whether the mother's mental health has improved or not. Thirty-four percent (396/1156) were confident/very confident that all HVs used routine outcome measures to assess the impact of any intervention they delivered to address maternal mental health issues. The last 2 statements taken to-gether suggest variations in the use of outcome measures. A number of reasons were given for the variation in perceptions of outcomes used and recorded. These included different views as to whether LVs were meant to be preventative, supportive or therapeutic and therefore the outcome measures that might be appropriate for each of these different objectives.

> *'I don't think I have always been very systematic in using the tools to record (hopefully) better outcomes. I suspect I am not alone.'*

TABLE 7.12. SYSTEMS FOR MEASURING PROCESS AND OUTCOMES

SURVEY QUESTION	YES	NO	DON'T KNOW/ NOT APPLICABLE
Q.6. Does your organisation have a system for recording the number of women who have their mental health assessed by a HV? (n=1527)	1157(76)	160(10)	210(14)
Q.6. Does your organisation have a system for recording the number of women with a MHP who receive an intervention from an HV? (n=1526)	786(52)	385(25)	355(23)
Q.6. Does your organisation have a system for recording the number of women who no longer have an MHP at the end of an intervention delivered by a HV? (n=1526)	339(22)	618(41)	569(37)

Outcomes need to be relevant to recipients of care and involve a broader remit than reduction of symptoms **(COLLINS, 2019)**. In the case of LVs further complexity arises from the need to consider impact and outcomes for all members of the family.

The Whooley questions, PHQ9, GAD7 or the EPDS were used before and after interventions offered by some HVs but comments indicated that some respondents felt that these were not the best tools for measuring meaningful outcomes. Alternatively, lack of clarity regarding the parameters of the intervention and the active ingredients needed to confer benefit made it difficult to know what to measure and increased the possibility of neutral outcomes or unintended (and possibly harmful) consequences.

> *'HVs are often uncertain as to what they have to do during a listening visit and how to document their activity on an electronic database. There is often a great deal of uncertainty as to whether the listening visits have been effective as HVs don't evaluate the visits.'*

Some respondents acknowledged the need to develop better indicators of maternally determined and clinically relevant measures of well-being for all members of the family.

> *'I think there really should be a way to measure the outcomes of these visits as it really is the basis of what we do as HVs by improving maternal mental health, we hope to improve infant mental health.'*

> *'The value of what HVs deliver needs to be quantified and recorded better so that organisations can evidence the excellent work that is happening already and demonstrate it becoming widespread – approx. 20% of our client base would benefit if we were able to reach all those who suffer.'*

> *'If I am honest sometimes listening visits do worry me because of my lack of training in mental health interventions (am I doing more harm than good, or am I doing anything at all to help Mum).'*

7.4.3.3. OBJECTIVE: TO DETERMINE WHETHER HVS BELIEVE THAT THEY HAVE THE NECESSARY KNOWLEDGE AND SKILLS TO SUPPORT MOTHERS WITH MHPS.

TDF Domain: Knowledge

Knowledge and skills are required for competent practice. Knowledge refers to an awareness of the existence of something **(ATKINS ET AL, 2017)**. Section 2 of the survey therefore sought to ascertain respondents' perceptions of their levels of knowledge regarding the causes, symptoms, impact and treatment of common perinatal MHPs. The findings suggest a cross-section of levels of knowledge with 18 – 51% respondents reporting very good knowledge in all 12 of the suggested parameters but at least 1 in 5 of the respondents reporting basic to fair knowledge in 7 out of the 12 parameters (Table 7.11, Fig 7.7). This might indicate that further training would be appreciated in these 7 parameters: prevalence of common perinatal mental illnesses; normal biopsychosocial processes of pregnancy and adaptation to motherhood; the importance of considering physiological/obstetric explanations for symptoms of mental illness; the potential impact of maternal mental illness on the father; the range of treatment options/ interventions available to help mothers with MHPs; the range of interventions available to promote positive and reciprocal mother-infant interactions; and ways of working with mothers to support the development of a therapeutic relationship.

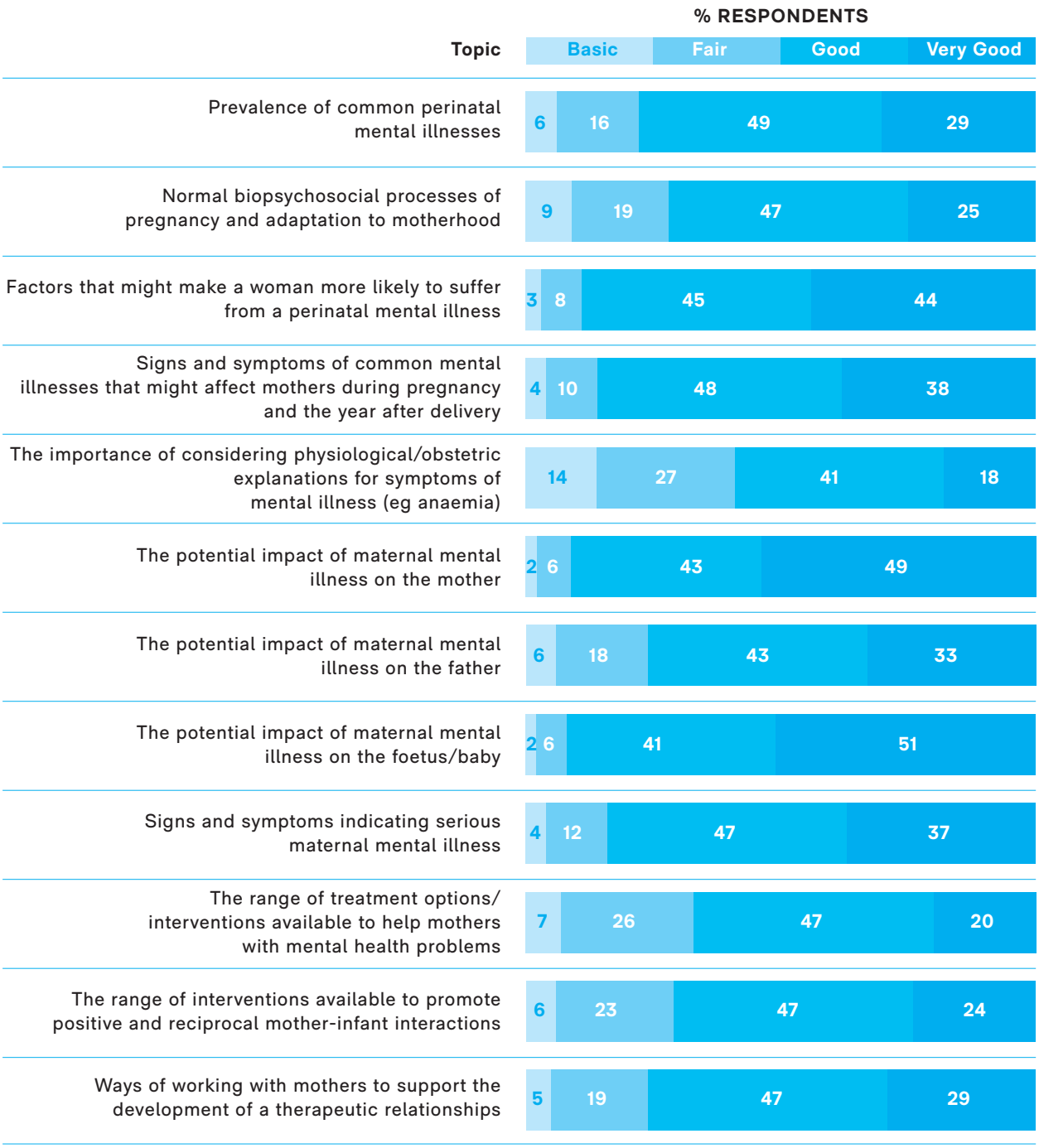
TABLE 7.13 SURVEY RESPONSES: HV KNOWLEDGE ABOUT THE CAUSES, SYMPTOMS, IMPACT AND TREATMENT OF PERINATAL MENTAL ILLNESS

SURVEY QUESTION

Q.7. When thinking about the cumulative effect of all the training that you have received in perinatal mental health, please indicate your level of knowledge in each of these areas.

	BASIC n(%)	FAIR n(%)	GOOD n(%)	VERY GOOD n(%)
Prevalence of common perinatal mental illnesses (n=1482)	90(6)	233(16)	734(49)	425(29)
Normal biopsychosocial processes of pregnancy and adaptation to motherhood (n=1477)	130(9)	280(19)	702(47)	365(25)
Factors that might make a woman more likely to suffer from a mental illness (n=1481)	44(3)	116(8)	666(45)	655(44)
Signs and symptoms of common mental illnesses that might affect mothers during pregnancy and the year following delivery (n=1480)	52(4)	153(10)	704(48)	571(38)
The important of considering physiological/obstetric explanations for symptoms of mental illness (e.g. anaemia) (n=1479)	213(14)	400(27)	594(41)	272(18)
The potential impact of maternal mental illness on the mother (n=1481)	31(2)	94(6)	634(43)	722(49)
The potential impact of maternal mental illness on the father(n=1481)	87(6)	267(18)	643(43)	484(33)
The potential impact of maternal mental illness on the baby(n=1481)	36(2)	86(6)	603(41)	756(51)
Signs and symptoms of serious mental illness (n=1477)	61(4)	182(12)	695(47)	539(37)
The range of treatment options/interventions available to help mothers with MHPs (n=1478)	107(7)	380(26)	693(47)	298(20)
The range of interventions available to promote positive and reciprocal mother-infant interactions (n=1480)	92(6)	329(23)	699(47)	360(24)
Ways of working with mothers to support the development of a therapeutic relationship (n=1475	80(5)	279(19)	698(47)	418(29)

FIG 7.9. HEALTH VISITOR SELF-RATED PERINATAL MENTAL HEALTH KNOWLEDGE (N = 1481)



TDF Domain: Skills

Skills refers to an ability, or proficiency, acquired through practice **(ATKINS ET AL, 2017)**. Nearly half of the respondents agreed with statements made by other HVs (and included in the survey) about the difficulty in defining LVs and the most appropriate techniques to use when supporting mothers with MHPs (Table 7.14). This is summed up by one of the respondents:

> *'I feel there is no standard throughout the health visiting service as to what skills individuals have or what they can offer women and their families to whom this affects. Some practitioners have varied skills and others less so, but this can mean it is pot luck as to the support women receive and hard for other services to know what we offer in visits and how we fit into the overall care and support for these families.'*

The techniques included in table 7.15./Fig. 7.10 are those in common use by HVs, described in the iHV briefing **(IHV, 2014)** issued following the launch of the updated NICE guideline in December 2014 **(NICE, 2014A)**. The highest % of respondents indicated that they frequently used techniques to promote mother-infant interactions (67%) and a non-directive counselling/person-centred approach (57%). The rest of the suggested techniques were frequently used by less than 50% of respondents, with the lowest percentage acknowledging frequent use of CBT techniques (14%).

Additionally, 378 free text responses referred to 18 other models and techniques that HVs used in the support that they offered to mothers with MHPs. These were grouped into the following categories: group-based support; psychoeducation; self-care; supporting the transition to parenthood; supporting partners and relationships; signposting and referrals. Given the variety of techniques described, it is not surprising that 70% (840/1196) of the respondents agreed/strongly agreed that LVs describe a package of care that may involve using a range of techniques and interventions (Table 7.14). Free text responses indicate that whilst some respondents felt that accumulated training in a range of techniques enhanced their perinatal mental health practice, others found the training too piecemeal to be effective.

> *'I think LVs have evolved , and now HVs use an array of different techniques, but the aim is the same- to provide emotional and psychological support in the most appropriate way for the individual.'*

> *'I don't feel very skilled at offering different models and techniques and feel that the training we receive is quite limited and rarely followed up.'*

> *'We have a small amount of training in mental health and some techniques of how we can support women but this does not seem to be sufficient or in-depth enough to manage some of the problems these women are experiencing.'*

The point was also made by many respondents that there is often too much focus on the theory rather than the practice and without sufficient back-up in terms of opportunities for reflection, supervision and regular updates, variations and inconsistencies in practice were likely to be perpetuated.

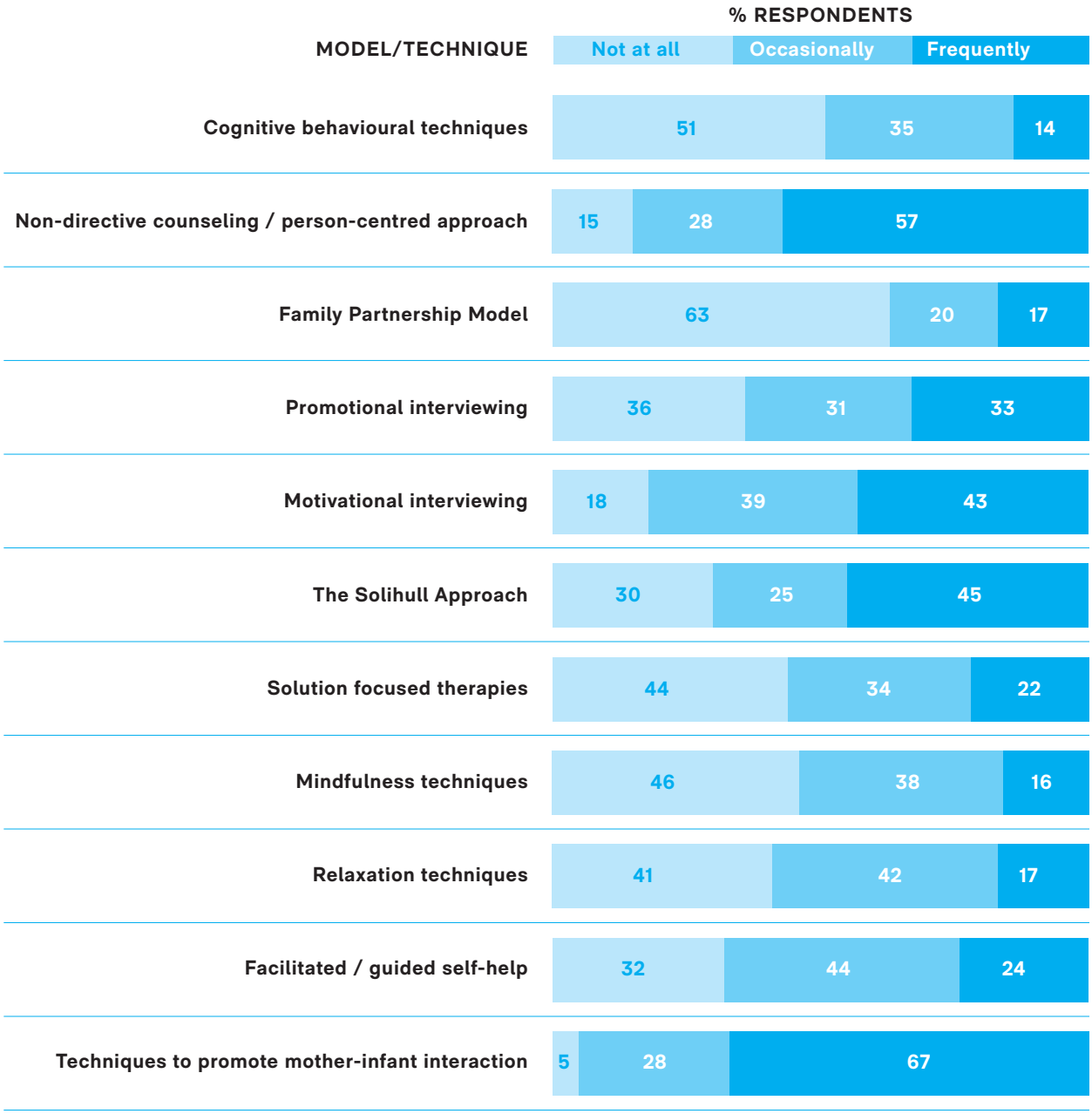
TABLE 7.14. SURVEY RESPONSES: DIFFICULTY IN DEFINING THE SKILLS NEEDED TO DELIVER LVS.

STATEMENT	STRONGLY DISAGREE n(%)	DISAGREE n(%)	NEITHER AGREE OR DISAGREE n(%)	AGREE n(%)	STRONGLY AGREE n(%)
Q.20. Health Visitors have had a little bit of training in a lot of different techniques. This makes it difficult to decide which techniques to use when providing support to women with mental health problems.(n=1252)	76 (6)	289 (23)	353 (28)	458(37)	76(6)
Q.20. 'Listening visits' are a bit of mystery. There doesn't seem to be any agreement on what they are or how to do them. (n=1250)	110(9)	297(24)	275(22)	457(36)	111(9)
Q.22.'Listening visits' describe a package of care that may involve using a range of different techniques and interventions. (n=1196)	20(2)	116(10)	220(18)	633(53)	207(17)

TABLE 7.15. SURVEY RESPONSES: MODELS AND TECHNIQUES USED BY HEALTH VISITORS IN THE SUPPORT THEY PROVIDE TO MOTHERS WITH MENTAL HEALTH PROBLEMS (N=1410)

SURVEY QUESTION			
Do you use the skills and knowledge acquired from attending training in any of the following models or techniques, in the work that you do with mothers with mental health problems?			
	NOT AT ALL n(%)	OCCASIONALLY n(%)	FREQUENTLY n(%)
Cognitive Behavioural techniques	723(51)	488(35)	191(14)
Non Directive Counseling techniques/person-centred approach	205(15)	401(28)	797(57)
Family Partnership Model	877(63)	275(20)	228(17)
Promotional Interviewing	505(36)	416(31)	464(33)
Motivational Interviewing	253(18)	533(39)	612(43)
The Solihull Approach	422(30)	352(25)	630(45)
Solution-focused Therapies	612(44)	471(34)	296(22)
Mindfulness techniques	642(46)	519(38)	227(16)
Relaxation techniques	563(41)	578(42)	243(17)
Facilitated/guided self-help	440(32)	614(44)	339(24)
Techniques to promote positive mother-infant interactions	68(5)	391(28)	951(67)

FIG 7.10. MODELS AND TECHNIQUES USED BY HEALTH VISITORS IN THE SUPPORT THEY PROVIDE TO MOTHERS WITH MENTAL HEALTH PROBLEMS (N=1410)



TDF Domain: Memory, attention and decision processes

This domain refers to the ability of the clinician to know what to do, to remember what to do and to be able to undertake a specific action or offer/deliver a specific intervention when it is appropriate to do so **(LIPWORTH ET AL, 2013)**. As has been previously stated, 88% of respondents (Table 7.11) have indicated that they have a clear understanding of what is meant by LVs and 85% of respondents (Table 7.3a) are currently offering LVs. These two findings suggest that the majority of respondents know what to do in LVs and when to offer them. However, there are also indications that a range of contextual factors influence the capability, opportunity and motivation of respondents to offer LVs that has generated an undercurrent of uncertainty regarding if, how, and when they should be offered. Relevant comments include:

'The structure of listening visits can be quite vague, no structure or guidance, snippets of how to manage with different tools and therefore not very helpful.'

'I do offer listening visits but have little capacity to provide what I would consider to be valuable.'
'My health visitor colleagues are very motivated in supporting women with mental health problems, however, time/staffing constraints all too often stop listening packages being put into place.'

7.4.3.4. OBJECTIVE: TO DESCRIBE THE CURRENT BELIEFS, ATTITUDES AND PRACTICE OF HVS WITH REGARD TO HOW THEY UNDERSTAND, ORGANIZE AND DELIVER THE SUPPORT THEY PROVIDE TO MOTHERS WITH MHPS, WHETHER OR NOT THIS SUPPORT IS DESCRIBED AS LVS.

TDF Domain: The nature of the behaviour

'Nature of the behaviour' includes the essential characteristics of the behaviour. Michie et al (2005) maintain that a clear description facilitates a shared understanding of what the intervention entails in order to identify opportunities for replication, reinforcement or change. Sustainability and effectiveness may be compromised if it is not possible to replicate the intervention with fidelity. The TIDieR checklist (TC) was developed to provide a systematic classification system to ensure that all descriptions of interventions include the same elements **(HOFFMAN ET AL, 2014)**. It has been used in this study to categorise commonalities and variations in HV perceptions of the structure, purpose and content of LVs. As there is some overlap with the domains of the TDF, the descriptions under some of the TIDieR checklist categories are necessarily brief. The following section headings reflect the categories of the TIDieR checklist.

TIDieR checklist category: Brief description of the intervention

This is meant to be a clear statement regarding what the intervention is called or a summary statement that facilitates easy identification of the type of intervention being described **(HOFFMAN ET AL, 2014)**. HVs were invited to indicate their agreement with a statement made by HVs (and included in the survey) regarding whether LVs is the most appropriate descriptive term for the intervention that they offer to mothers with MHPs. Sixty-nine percent of respondents (852/1250) agreed/strongly agreed that the term did not adequately describe what HVs do (Table 7.16a). Comments from the respondents revealed variations in the interpretation of the meaning of LVs by HVs, managers and commissioners. Comments ranged from suggesting that 'listening' adequately described the HV intervention because that was what it was fundamentally about, to a suggestion that it is an inadequate description for such a complex intervention and was, anyway, what all HVs 'do' during the course of every interaction that they have with mothers. Respondents who were aware of the original research introducing LVs **(HOLDEN ET AL, 1989)** felt that the term was developed to encompass an intervention solely guided by NDC and therefore it was not an appropriate 'umbrella' term to use when directive techniques were included. It was also suggested that as the intervention was specifically designed for, and tested on, mothers with PND that it was not appropriate to refer to LVs as an intervention for mothers with other MHPs.

TABLE 7.16A. SURVEY RESPONSES: ARE 'LISTENING VISITS' AN APPROPRIATE DESCRIPTIVE TERM FOR THE SUPPORT THAT HVS PROVIDE TO MOTHERS WITH MHPS?

STATEMENT	STRONGLY DISAGREE n(%)	DISAGREE n(%)	NEITHER AGREE OR DISAGREE n(%)	AGREE n(%)	STRONGLY AGREE n(%)
Q.24. The term 'listening visit' does not adequately describe the support that health visitors give to mothers with mental health problems. (n=1250)	30(2)	141(11)	227 (18)	645(52)	207(17)

Questions 28, 29 and 30 of the survey invited respondents to state whether they thought the intervention they offered should be called 'LVs', 'facilitated self-help,' or something else. The results are presented in Table 7.16b and suggest a lack of consensus regarding what the intervention should be called. 358 respondents offered comments in response to Q.30 – If you are not happy with the term 'LVs' or 'facilitated self-help', do you have any ideas about a better way of describing/referring to the intervention offered by HVs to mothers with MHPs? A variety of other labels were suggested alongside comments asserting that it doesn't matter what the intervention is called as long as it is acceptable and non-threatening to mothers and provides the type and level of support they need.

> *'I think it is an over-thought process coming up with a phrase to describe offering support, care, kindness and time to a client who is struggling with a phase of their life'*

The lack of consensus makes it impossible to provide a universally agreed description of LVs.

TABLE 7.16B SURVEY RESPONSES: ARE 'LISTENING VISITS' AN APPROPRIATE DESCRIPTIVE TERM FOR THE SUPPORT THAT HVS PROVIDE TO MOTHERS WITH MHPS?

QUESTION	YES n(%)	NO n(%)	MAYBE n(%)
Q.28. Do you think that the package of care that HVs offer to mothers with MHPs should be called LVs? (n=1144)	377 (33)	312 (27)	455 (40)
Q.29. Do you think that the package of care that HVs offer to mothers with MHPs should be called 'facilitated self-help'? (n=1125)	163 (15)	488 (43)	474 (42)

7.4.3.5. OBJECTIVE: TO DESCRIBE THE CORE COMPONENTS THAT HVS THINK SHOULD FORM THE BASIS OF A HEALTH VISITOR-LED INTERVENTION.

TIDieR checklist category: Rationale, theory or goal of the elements of the intervention

The following two quotes from HVs eloquently capture the views expressed by many other respondents in their free text responses regarding the rationale for, and goals of, LVs.

> *'My understanding of LVs, i.e. what I do, is to offer an opportunity to unload in an empathic, non-judgemental environment, in the first instance. Then to explore the origins, context and triggers for the current experience. Through developing a greater insight into one's own difficulties and a greater awareness about one's own responses, mothers can begin to reframe their perceptions and regain control. Often there are underlying issues (family, relationships, loss, trauma) which have been unearthed by the momentous life event of motherhood. Sometimes the pregnancy and birth itself is a trauma. One fairly key thing is to communicate the normality of it. Mental illness is often a normal reaction to difficult life experiences. One thing I aim to achieve through normalising is to 'dilute' the symptoms e.g. an anxious mother experiences the symptoms of anxiety PLUS the worry about the fact that she feels anxious 'am I going mad?' etc. At the very least I hope to reduce the worry about worrying, to let the mother know that she is not alone, she will recover, that many others experience the same thing.'*

> *'The term LVs is a collective. HVs are able to offer support with positive lifestyles, positive behaviours, eating, routines, exercise, enjoyable activities, realistic expectations of parenthood, maternal bond/ attachment etc which would promote healthier mental health.'*

There is an indication that survey respondents recognise the need for a pluralistic approach to identifying need and providing support. Respondents frequently stated that the goals of the intervention depended on what mothers were experiencing and what they felt might be helpful. The findings that only 34% (396/1156) were confident that routine outcome measures were used to measure the effectiveness of the HV intervention may reflect the difficulties in capturing maternally relevant as well as clinically significant indicators of recovery, especially when there are underlying variations in HV opinions about the purpose of LVs.

In their guidance on how to use the TIDieR checklist, Hoffman et al (2014) state that this category (rationale, theory or goals of the intervention) can alternatively be interpreted as a description of the components of a complex intervention. The essential components should be differentiated from those that are optional.

Respondents were asked to choose the elements, extracted from the literature reviews reported in previous chapters, that they thought should be included in a HV perinatal mental health intervention. Of the 17 suggested elements, the majority of respondents felt that they all should possibly, or definitely, be included in an intervention offered by HVs (Table 7.17, Fig 7.11).

TABLE 7.17. SURVEY RESPONSES: VIEWS OF HVS ABOUT THE ELEMENTS THAT SHOULD BE INCLUDED IN AN HV INTERVENTION FOR MOTHERS WITH MHPS

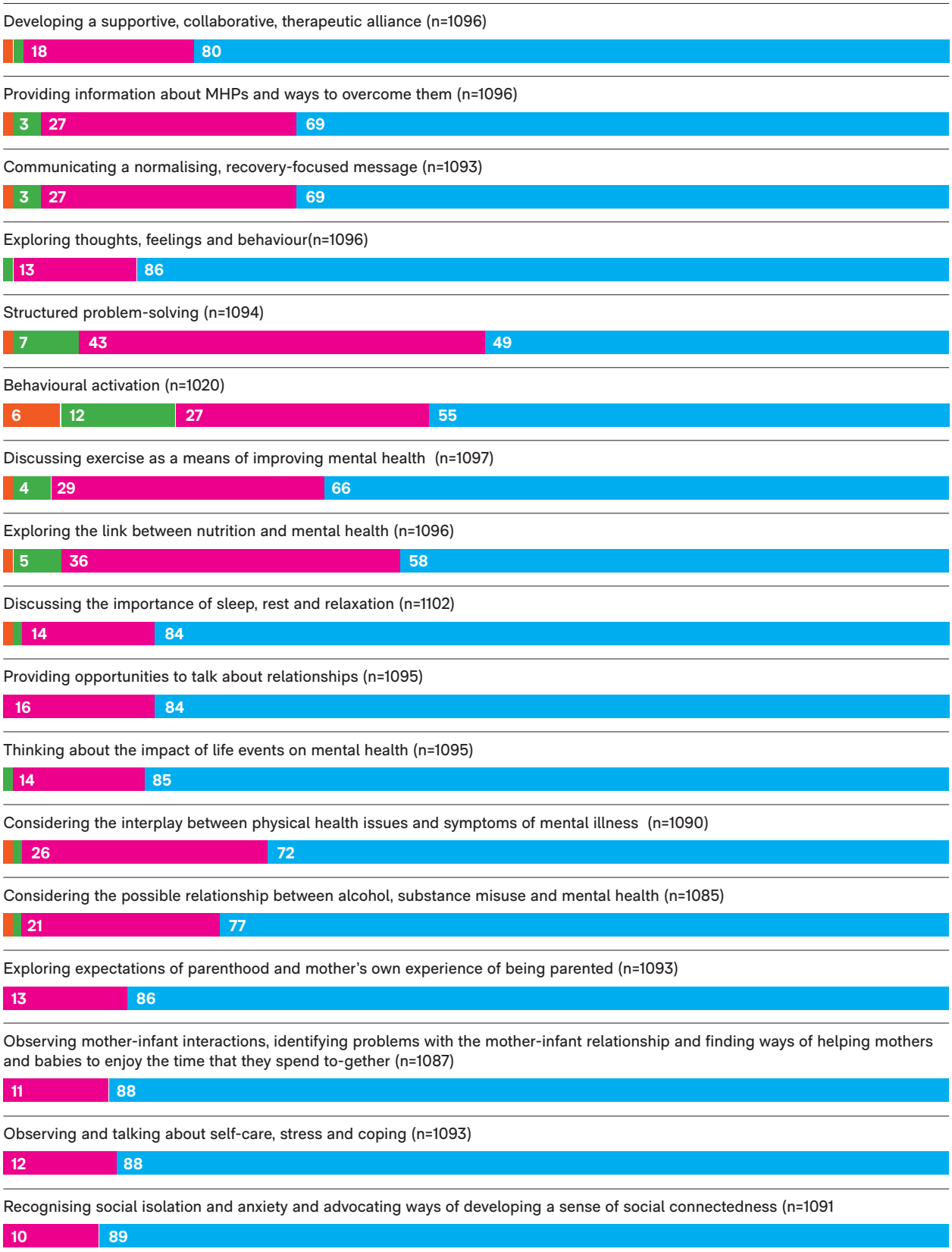
QUESTION

What do you think are the key elements of an intervention framework that should underpin the work that health visitors do with mothers with mental health issues?

	NO OPINION	SHOULD NOT BE INCLUDED	POSSIBLY SHOULD BE INCLUDED	SHOULD BE INCLUDED
Developing a supportive, collaborative, therapeutic alliance (n=1096)	6(1)	10(1)	200(18)	880(80)
Providing information about MHPs and ways to overcome them (n=1096)	6(1)	37(3)	291(27)	763(69)
Communicating a normalising, recovery-focused message (n=1093)	12(1)	31(3)	292(27)	758(69)
Exploring thoughts, feelings and behaviour(n=1096)	3(*)	11(1)	143(13)	939(86)
Structured problem-solving (n=1094)	15(1)	78(7)	469(43)	532(49)
Behavioural activation (n=1020)	60(6)	121(12)	482(27)	357(35)
Discussing exercise as a means of improving mental health (n=1097)	7(1)	44(4)	320(29)	726(66)
Exploring the link between nutrition and mental health (n=1096)	13(1)	54(5)	397(36)	632(58)
Discussing the importance of sleep, rest and relaxation (n=1102)	7(1)	12(1)	155(14)	928(84)
Providing opportunities to talk about relationships (n=1095)	3(*)	6(*)	181(16)	905(84)
Thinking about the impact of life events on mental health (n=1095)	4(*)	8(1)	156(14)	927(85)
Considering the interplay between physical health issues and symptoms of mental illness (n=1090)	7(1)	14(1)	283(26)	786(72)
Considering the possible relationship between alcohol, substance misuse and mental health (n=1085)	6(1)	13(1)	228(21)	838(77)
Exploring expectations of parenthood and mother's own experience of being parented (n=1093)	3(*)	3(*)	144(13)	943(86)
Observing mother-infant interactions, identifying problems with the mother-infant relationship and finding ways of helping mothers and babies to enjoy the time that they spend to-gether (n=1087)	3(*)	4(*)	119(11)	961(88)
Observing and talking about self-care, stress and coping (n=1093)	3(*)	5(*)	127(12)	958(88)
Recognising social isolation and anxiety and advocating ways of developing a sense of social connectedness (n=1091	2(*)	4(*)	109(10)	976(89)

(*) – less than 1%

FIG 7.11. VIEWS OF HVS ABOUT THE ELEMENTS THAT SHOULD BE INCLUDED IN AN HV INTERVENTIONS FOR MOTHERS WITH MHPS



TIDieR checklist category: Physical or informational material used in the intervention

The explanation given in the TIDieR checklist guidance for this category is that it should include the 'ingredients' necessary to deliver the intervention including physical or informational materials used in the training of intervention providers **(HOFFMAN ET AL, 2014 P.4)**. Reference has already been made to the limited number of respondents who have access to a handbook/manual/guidance and the 72% of respondents who would like one.

TIDieR checklist category: Procedures, activities and processes used in the intervention

The different models and techniques used as a foundation for the support that HVs provide to mothers with MHPs are illustrated in table 7.15, Fig. 7.10. Many HVs have expressed concerns that, due to contextual constraints, they are unable to offer LVs in a format compatible with their expectations of an effective and acceptable intervention. Despite the difficulties in clearly defining what LVs are, there is a generic sense of the activities and process of delivering LVs in some of free text comments. As well as the specific models and techniques that have been mentioned, survey respondents also allude to the importance of basic nursing skills required in any interaction with families and, in the context of perinatal and infant mental health, to consider the mother, the baby and the relationship between them.

> *'In my view a package of listening visits (6-8) should be offered to mothers assessed as having mild to moderate depression. These visits are opportunities for the mother to talk about anything that is bothering her. The practitioner uses nondirective counselling techniques and whatever other skills she has that are appropriate to help support the mother. This could be a practical problem -solving approach or reflective listening or CBT techniques etc.'*

> *'There is a clearly defined movement through from the first to the last LV and the process before and afterwards depending on the assessment, movement and outcome of the interventions.'*

> *'It is important to approach a LV with a sense of not knowing and wondering together with the parent. Observation is important, observation of the infant and the way the parent and infant relate can offer cues about the relationship and the impact the mother's mental health is having on the baby . . . are they gaze avoidant, irritable, hyperalert or hypervigilant. Parents are different and some mothers may ask for direction, others just need to talk, or just need the health visitor to be alongside them, listening actively and reflecting back to them what they have understood.'*

TIDieR checklist category: Expertise, background and specific training given to the intervention provider.

The guidance for this category suggests that it is important to review the competences that are needed to deliver the intervention and how they are acquired and assessed **(HOFFMAN ET AL, 2014)**.

NHS Scotland have developed a perinatal mental health curricular framework that sets out the different levels of knowledge and skills required by different practitioners within the Scottish workforce **(NHS EDUCATION SCOTLAND, 2019)**. In England, The Royal College of General Practitioners and the Royal College of Psychiatry have developed perinatal mental health curricula or toolkits for their members. Although HEE, in collaboration with the Tavistock & Portman NHS Foundation Trust, has developed a competency framework to indicate the knowledge and skills needed by practitioners providing different levels of perinatal mental healthcare **(HEE & TAVISTOCK & PORTMAN TRUST, 2018)**, as far as I am aware, a nationally agreed curriculum regarding the content and training materials needed to train HVs has not yet been devised.

Forty-seven percent of respondents thought that they had not received sufficient training in how to deliver LVs with a further 26% uncertain about whether they had received sufficient training (Table 7.8) Table 7.9 and Fig 7.4 indicates the accessed and preferred formats of training. The largest proportion of HVs wanted a series of lectures/workshops (67%), regular training updates (70%) and a manual/handbook on how to deliver LVs (72%). These findings would suggest that learning materials need to be developed and standardised and the training required and available needs to be clearly specified.

A cautionary note is needed in the sense that different individuals learn in different ways and may need exposure to multiple and repeated learning opportunities to achieve competence and confidence in practice. Survey responses suggest that the small amount of training that is provided to HVs is not sufficiently extensive, frequent enough, or with adequate opportunities to try things out, observe others and consolidate knowledge in practice, to confer competence and confidence in assessment and support.

> *'I think it is a crying shame that these visits are a huge part of our caseload's core work – yet NO training is provided.'*

> *'Most health visitors who speak to me say they need more training despite having had a lot of training and support. It's a confidence thing. I took a HV out with me to witness my LV assessment and she was amazed at how much was gained after just that one session. They want to be shown, to witness, to see role plays. To try it out, to be told that they don't need all the answers, that it's the therapeutic relationship that usually heals.'*

Respondents also commented on the intention of some organisations to train members of the HV team, such as staff nurses or nursery nurses, to deliver LVs. This was considered essential and inevitable by some respondents. Others thought that this would be inappropriate and inadvisable given their prior training and professional remit, the need for sensitivity and practical wisdom in exploring and understanding disconnected mother-infant relationships, the additional skill and insight needed to continuously monitor risk and mental state, and the potential of emotional distress for the staff nurse or nursery nurse as a result of exposure to signs and symptoms of serious mental illness. Respondents also raised concerns that HVs supporting mothers with long-term MHPs may feel obliged to provide support that is outwith their scope of practice.

TIDieR checklist category: Modes of delivery

Face-to-face contact is reported in the free text responses as the preferred mode of delivery. Some respondents expressed concern that they were being expected to see mothers in busy clinics or conduct LVs over the phone.

TIDieR checklist category: Location

Comments were made affirming that respondents believe that one of the unique aspects of HV support is being able to deliver LVs in maternal homes.

TIDieR checklist category: Timing, duration and frequency of the intervention

Eighty-seven percent (1048/1202) of respondents agreed/strongly agreed that the term 'listening visits' includes the offer of 4-6 visits (in the first instance) although 74% (883/1194) also agreed/strongly agreed that a LV can be a stand-alone visit. Sixty-three percent (747/1195) agreed/strongly agreed that each LV is expected to last about 45 minutes (Table 7.16). Variations in the number of visits planned or possible and the duration and frequency of LVs was evident from the free text responses.

TABLE 7.18. SURVEY RESPONSES: HV BELIEFS ABOUT LVS

STATEMENT	STRONGLY DISAGREE n(%)	DISAGREE n(%)	NEITHER AGREE OR DISAGREE n(%)	AGREE n(%)	STRONGLY AGREE n(%)
Q.22. The term 'listening visits' includes the offer of 4-6 visits (in the first instance) from a health visitor. (n=1202)	11 (1)	54(5)	89(7)	604(50)	444(37)
Q.22. A 'listening visit' can be a stand- alone visit.(n=1194)	40(3)	151(13)	120(10)	684(57)	199(17)
Q.22. Each 'listening visit' is expected to last about 45 minutes.(n=1195)	16(1)	133(11)	299(25)	580(49)	167(14)
Q.22.'Listening visits' are always based on non-directive counselling or a person-centred approach.(n=1192)	18(2)	136(11)	271(23)	577(48)	190(16)
Q.22. 'Listening visits' are always based on a cognitive behavioural approach. (n=1188)	86(7)	505(43)	509(43)	77(6)	11(1)
Q.22. 'Listening visits' involve using evidence-based information to help mothers regain their self-management abilities when these have been adversely affected by mental distress. (n=1196)	15(1)	68(6)	277(23)	645(54)	191(16)
Q.22. 'Listening Visits' include consideration of maternal well-being, the mother-infant relationship and family and social networks.(n=1199)	8(1)	6(1)	38(3)	658(55)	489(40)
Q.22. At the end of 4-6 'listening visits' an appropriate assessment tool is used to assess whether the mother's mental health has improved or not.(n=1199)	18(1)	80(7)	142(12)	574(48)	385(32)

TIDieR checklist category: Tailoring of the intervention

Tailoring refers to adapting the intervention to the needs of the individual patient **(HOFFMAN ET AL, 2014)**. Variations in the duration, frequency and content of LVs were described depending on the needs and preferences of the mother, changes in the range and severity of maternal symptoms and the availability of other services.

> *'I suspect we all work quite differently when providing support. As this probably makes our intervention person-centred it is not necessarily a bad thing.'*

> *'I feel that most HVs will undertake LVs in many different ways. It depends very much on HV experience, training and life skills and the client's need at the time. LVs cannot be uniform. They must be tailored to meet and support the client and the level of anxiety or depression the client is experiencing.'*

> *'I think it should be the HV's own clinical judgement and experience as to how and how often LVs should be offered/done according to the needs of individual mothers and families on their caseload. I work in a very challenging area, where often there are complex cases, and things don't fit into neat boxes.'*

TIDieR checklist category: Modifications of the intervention

Modifications refer to changes in the intervention that are imposed as a result of extenuating or unforeseen circumstances that mean that the intervention cannot be delivered with fidelity **(HOFFMAN ET AL, 2014)**. Further modifications to LVs occurred as a consequence of workforce shortages, HV preferences, conflicting priorities or the delegation of support for mothers with MHPs to other professionals or services.

'Current staffing levels mean that we are not always able to offer a series of visits, but we may be able to offer 1 or 2 follow up visits if a need has been identified.'

'In times of priority working these visits are often the first to go. Whether that is through management directive or HVs who don't like offering them taking the opportunity to drop them I'm not sure.'

TIDieR checklist category: Assessing intervention adherence

It is difficult to assess intervention adherence if the parameters of the intervention or the competencies required to deliver it are not clearly stated. It is therefore not surprising that only 11% of respondents were confident/very confident that systems were in place to monitor HV competence and 17% (198/1159) were confident/very confident that systems were in place to monitor and evaluate treatment adherence (Table 7.10).

TIDieR checklist category: Intervention adherence

It is not possible to assess intervention adherence for all the reasons given in the previous section.

7.4.3.6. OBJECTIVE: TO EXPLORE WHAT HVS BELIEVE IS NEEDED TO ENABLE THEM TO PROVIDE EFFECTIVE SUPPORT TO MOTHERS WITH MHPS.

Question 33 in the survey was an open-ended question that invited respondents to state what needs to be done to improve the support that HVs provide to mothers with MHPs. 731 responses were received. These were imported into NVIVO software and thematically analysed (Table 7.17).

TABLE 7.19. INDUCTIVE THEMES ARISING FROM HV VIEWS ABOUT WHAT NEEDS TO BE DONE TO IMPROVE THE SUPPORT THAT HVS PROVIDE TO MOTHERS WITH MHPS

THEME (TOTAL NUMBER OF COMMENTS = 1,501)	MAIN ISSUES
Role of HV	Need more time to fully and holistically support mothers and fathers mental health and transition to parenthood; HVs to have manageable caseloads (maximum – 250 children under 5); more emphasis placed on parental mental health in HV training and recruitment; restore HV professional autonomy and integrity to manage own caseload and provide family-centred care/support groups as needed; re-instate the value and importance of LVs as an integral component of HV role and restore 3-4 month mental health assessment; A/N HV assessment should be much earlier and include greater emphasis on maternal mental health (psychoeducation and assessment); HVs to have more influence on Children's Centres provision; HV specialist/champion to ensure optimal care for families and optimal support for HVs including regular updates and protected time for reflection and supervision.
Assessment	Review of process and content of assessment. Current assessment tools not considered comprehensive enough to detect range of mental health symptoms and needs.
Intervention	Need to provide information about range of emotional changes that might happen during pregnancy and post-birth (possibly in groups); Need clearly defined, structured intervention to give some ideas about issues to discuss/goal setting/range of techniques/responses that can be offered and what to do at the end of 6 visits; need to include needs of mother, partner and baby, lifestyle interventions and strengths-based approaches; need greater understanding of cultural variations in expression, interpretation of symptoms and preferred interventions.
Guidance	Need handbook/manual/clear guidance/framework for HVs on assessment, interventions and outcomes; need a definitive evidence-based framework to guide practice whilst maintaining flexibility to respond to parental preferences and needs; hand-outs for each session – a system similar to promotional guides would help to structure conversations; agreement about a unified approach that is nationally recognized and evidence-based.
Information and resources to share with clients	A toolkit of local and national information to share with clients; a visual means to show a client their deteriorating or improving mental health at each LV; leaflet to signpost to resources and self-help; resources to assist women with identifying triggers, practice techniques etc; dairies/workbook for Mums; information leaflet about role of HV in supporting mothers with MHPs; ideas/resources to help mothers get out of the house.
Evaluation	HVs need clear evidence-based tools and outcome measures that are used consistently to demonstrate effectiveness; need to evaluate satisfaction as well as effectiveness; effectiveness needs to be related to maternal goals not just symptom reduction; need better system for collecting stats about assessments, interventions and outcomes; Collation of data should help to ensure consistent, high quality, equitable provision.
Training	All staff in HV teams should have basic training in maternal paternal and infant mental health; need better, evidence-based, comprehensive, up-to-date, validated, blended learning opportunities in assessment and interventions; regular updates including input from mental health practitioners and experiences of mothers; regular reviews of HV competency (possibly like an OSCE). Opportunities for multi-agency training, supervision and regular updates are needed.
Additional support or services	Need regular contact with GPs, maternity and mental health services and voluntary organisations to ensure collaborative care and seamless pathway of timely, appropriate support; need access to mental health specialist for advice; need greater variety of flexible, responsive, accessible services including more opportunities for community support/social interaction.
Commissioning/ management	Need increased recognition and understanding of important contribution of HVs to maternal, paternal and infant mental health by commissioners, social care and senior managers; there needs to be a KPI (key performance indicator) linked to the HV role in perinatal and infant mental health that includes acknowledgement of prevention/early intervention; need to employ enough HVs to ensure time to deliver quality maternal mental health interventions; caseload weighting needs to include potential number of mothers with MHPs; need to improve public awareness of prevalence, impact and services available to support mothers with MHPs.
Policy, protocols and pathways	Increase number of HVs; increase number of mandated visits (including mandated visits for maternal mental health); give higher priority to HV role in prevention and early intervention with accompanying increase in capacity and resources; have new HV implementation plan. Local protocols and pathways need to be developed in collaboration with the professionals expected to enact them and should be widely shared so that all professionals know what is expected of them. These should be subject to regular review.

7.5. Discussion

As far as I am aware, this is the largest study of the attitudes, beliefs and perinatal mental health practice of HVs/public health nurses. The comprehensive responses to the 9 open-ended questions provided a rich seam of qualitative data that help to contextualize the quantitative findings and illustrate the importance and depth of feeling attributed by HVs to this topic.

The map (Fig 7.1) indicates a reasonable geographical distribution of responses across the UK. The range of training and experience in health visiting and perinatal and infant mental health amongst the respondents suggests that a range of expertise is represented. Although respondents to surveys are often those with strongly held views about the subject under investigation, the distribution of location, experience and expertise increases confidence that the respondents are representative of a cross-section of the target population.

The TDF facilitated a systematic approach to question formulation and analysis of qualitative data. The 12 Domains of the original version, derived from organizational and psychological theory, facilitate the identification of specific aspects of implementation that otherwise might not have been exposed. For example, the domain of emotion is particularly relevant in terms of thinking about the impact on health visitors of managing the uncertainty of not knowing if they are doing the right thing, dealing with maternal psychological distress when they may be experiencing emotional difficulties themselves, struggling with unmanageable expectations due to workforce shortages, or feeling that they are required to practice beyond the limits of their competence without access to requisite training and supervision.

Environmental influences helped to identify the factors determining perceived behavioural control such as the expectations of commissioners and managers, the existence of protocols and pathways and capacity restrictions curtailing the time available to deliver LVs. A common theme was the lamented absence of a key performance indicator for maternal mental health, which meant that information about health visitor perinatal mental health interventions was not required by commissioners and was therefore not a priority and not funded. This reduced the provision of support to mothers with MHP's to an 'optional extra' which could only be undertaken once the targets for performance had been achieved. Due to workforce pressures, some respondents felt obliged to restrict the frequency or number of visits included in the intervention they offered or had to make pragmatic decisions to only offer support as, and when, they had the capacity to do so. This inequity of provision is likely to have the effect of subverting the effectiveness of the intervention and increasing inequalities in health.

Respondents have suggested that protocols and guidelines need to be developed, regularly updated, discussed and shared with all relevant health professionals, to ensure that they are possible to enact and that they inform and reflect what is actually happening in practice. Multiprofessional training needs to be secured that helps to differentiate the particular knowledge and skills of each professional group to enable them to provide collaborative, integrated care and seamless transition for mothers between services. Integration of services should utilise complementary skillsets. For example, to enable inter-organisational provision of consultation and supervision.

Maternal mental health and early intervention have been identified as government priorities **(PUBLIC HEALTH ENGLAND 2016A, 2016B)**. Failure to identify mothers who would benefit from a therapeutic intervention has been identified as one of the biggest barriers to reducing adverse consequences **(KHAN 2015, HOWARD ET AL 2014)**. It is difficult to understand the logic of reducing health visitor mandated

contacts at 6-8 weeks or to understand how the 3-4 month maternal mental health assessment specified in the 2015/2016 national health visitor service specification has been allowed to slip into obsolescence **(NHS ENGLAND 2014)**. As respondents in the survey pointed out, mothers may not be seen between the 6-8 week contact (if there is one) and the 7-12 month mandated contact. This coincides with a period of time when mothers are particularly vulnerable to mental health issues.

Many respondents were motivated to provide the best support they could, given their level of knowledge, skill and experience and the limitations imposed by aspects of context. Some respondents were required to offer LVs without having received adequate training. Absent or insufficient training can foster feelings of inadequacy and lead to avoidance of engagement with potential intervention recipients. Without adequate training, professionals are likely to hold pessimistic views about the 'reality and likelihood of recovery' **(KNAAK ET AL, 2017 P.112)**. Training on its own is not sufficient to confer consistent, competent, confident care. HVs need to know exactly what it is they have to do; have access to a more knowledgeable other to provide opportunities for observation and reflection; have enough time to practice and consolidate new skills; and supervision to facilitate discussion of challenging cases, provide reassurance about optimal practice and ensure avoidance of emotional burn-out.

The intention of the original LV protocol **(HOLDEN ET AL, 1989)** was to enable HVs to provide support to mothers with PND that would lead to a reduction in symptoms of depression. The landscape of perinatal mental illness and care has changed since 1989 with greater awareness about the diversity and impact of symptoms and treatment. HVs need to be trained in the causes, range, presentation, impact and management of mental health symptoms that women might experience as well as the 'interaction of complex psychosocial factors and psychological health' **(NOONAN ET AL 2016 P.553)**. This survey echoes the findings of surveys of the views of public health nurses in the Republic of Ireland **(HIGGINS ET AL 2017; NOONAN ET AL, 2019)** and a metasynthesis of the views of public health nurses from 6 countries **(NOONAN ET AL 2016)**, regarding their role in perinatal mental health care. All of these studies concluded that more training covering a broader range of topics and skills is needed to enable HVs to provide effective support that promotes theemotional wellbeing of all members of the family.

There is also a more serious implication of absent or inadequate training. All nurses are bound by a professional code of conduct to do no harm. Some respondents raised concerns that untrained HVs delivering 'listening visits' might perpetuate maternal ruminatory thinking with the potential to aggravate symptoms of mental ill-health and compromise mother-infant interactions **(DEJONG ET AL, 2016)**. This provides further justification for compulsory training for all HVs in how to deliver perinatal mental health interventions safely and effectively.

Beliefs about capabilities arise from personality traits, experience and training. As many respondents affirmed, one-off training will not change practice. Systems and tools need to be developed to assess HV competence, treatment fidelity and maternal satisfaction with intervention and outcomes. It is evident from both the quantitative and qualitative responses that systems for monitoring practice and outcomes are largely absent, although much needed, to overcome the concerns that some respondents have about standardizing and sustaining the quality, content and effectiveness of the intervention that is being offered.

Outcomes that matter to individuals with MHPs may not be those that are routinely measured (COLLINS, 2019). A more balanced approach that captures the range of emotions, symptoms and experiences that mothers have during pregnancy and the year after delivery is required. The conventional focus on deficit and risk needs to be tempered with assessment of quality of life, emotional and physical adjustment to parenthood and maternal capabilities, resilience and resources (WADEPHUL ET AL, 2020). Additional or alternative outcome measures need to be developed that reflect maternally determined goals, clinically significant outcomes and the impact of maternal mental ill-health on all members of the family.

Although 88% of respondents had a clear understanding of what is meant by LVs and 85% offered LVs, it would appear from the free text responses that there is not a shared agreement about what LVs entail in terms of their structure, content and purpose. Many respondents wanted a more consistent, standardized approach.

The majority of respondents supported the proposition that LVs are a multicomponent intervention tailored to the needs, preferences and circumstances of mothers. The highest rated elements were recognizing social isolation, promoting positive mother-infant relationships and talking about self-care, stress and coping. Whilst some respondents maintain that non-directive counseling was the technique used to underpin the original LVs and should not be used in association with other more directive strategies, it is clear that, for many HVs, LVs is now used as an umbrella term for an intervention of varying frequency, duration and purpose, involving the use of a range of models and techniques. Any techniques that are used should still be evidence-based and only used by practitioners who are trained and supported in their delivery, in order to maintain competence and efficacy. As the focus of the HV intervention is much more diverse than it used to be (when the concept of LVs was introduced) It is likely that both assessments and interventions may take more time in order to ensure the appropriateness and acceptability of the intervention. At least 4 therapeutic sessions appear to be necessary to confer benefit (DELGADILLO ET AL, 2014).

The diversity of views makes the intervention difficult to describe, replicate, sustain and commission. Use of the TIDieR checklist to explore current practice in order to make recommendations about what should happen in the future confirms that, based on HV responses to this survey, it is impossible to clearly define what HVs are doing for nearly every category of the checklist. The variations in interpretation and practice also make it difficult to design and deliver appropriate training programmes. Evaluating maternal satisfaction and outcomes is complicated by the lack of coherence regarding the purpose and content of the intervention.

Many of the HVs who responded to this survey were seeking greater clarity about the format, structure and function of a health visitor led intervention that may, or may not, be described as LVs. Many respondents highlighted the need for a standardized, structured evidence-based approach that included sensitive, comprehensive and ongoing assessment was guided by a manual and informed by multimodal training updated at regular intervals, delivered by experienced trainers, and consolidated through opportunities for reflection, practice and supervision.

7.6. Strengths and limitations

The poor response rate (17%) undermines the generalisability of the findings, although response rates of health professionals to on-line surveys of less than 20% are not uncommon **(DYKEMA ET AL, 2013)**. The length of the survey may have been a deterrent to completion as over 2,000 HVs commenced the survey, so at least 400 views were not captured. In an analysis of 25,080 web-based surveys, Liu and Wronsky (2017) found a relationship between survey length and survey completion. Non response-bias may be more useful in determining the validity of survey findings although probably the only means of doing this would be by use of another survey!

Although the matrix question format is commonly used to present a large amount of options in a smaller amount of space, there may have been too many questions of this type. Some important issues may have been omitted. For example, the question about received and preferred format of training did not include interactive e-learning or blended learning opportunities. Whilst it may be useful to explore why respondents respond in the way that they do to specific questions, too many open-ended questions may also act as a deterrent to completion of the survey. Survey fatigue (frequent invitations to complete surveys) may also have an impact on the overall response rate. Members of the iHV are invited to complete a 'State of Health Visiting' survey in November every year and other surveys are also circulated by the iHV to their members on several occasions throughout the year.

The combination of deductive and inductive analysis of the free text responses helps to ensure a recognised systematic approach to the analysis of the determinants of practice but also acknowledges the importance of representing the 'voice' of the respondents **(SANDELOWSKI, 2006)**. Lipworth et al (2013) have demonstrated the benefits of using the TDF to analyse health professionals' perceptions of clinical interventions. In their analysis of 50 qualitative studies, they found that the TDF accounted to 'a considerable extent for the barriers to, and facilitators of, behavior change in the clinical quality context' **(LIPWORTH ET AL, 2013 P.10)**.

The commonality with issues identified in other surveys adds to the credibility of the findings of this survey **(CUMMINGS AND WHITTAKER, 2016; CUNNINGHAM & GALLOWAY, 2018; HIGGINS ET AL, 2017; NOONAN ET AL, 2019)**. A more robust comparison could have been facilitated by emulating the questions/tools used in these studies. It may have been more informative to assess actual levels of knowledge rather than self-rated knowledge, or to assess both and analyse the similarities and differences between the two **(WADEPHUL ET AL, 2018)**. Wadephul et al (2018) include attitudes as one of the five domains of the framework they have developed for assessing the ability of midwives to identify, assess and care for women with MHPs. Attitudes, in this context, included attitudes towards women with MHPs as well as midwifery attitudes towards the provision of care. Assessment of HV attitudes towards perinatal mental illness may also have provided insight into how knowledge gained through training is interpreted and applied **(WADEPHUL ET AL, 2018)**. The skills needed to establish and maintain a therapeutic relationship conducive to disclosure and recovery are difficult to teach and evaluate. These Interpersonal skills may be the most important determinants of optimal outcomes.

7.7. Conclusions

The findings from a survey of HVs demonstrates the importance of exploring their attitudes, beliefs and practice in order to clarify their role in supporting mothers with MHPs. It is clear that despite the contextual issues that have added to the confusion regarding the concept of LVs, the majority of HVs believe that supporting mothers with MHPs is a fundamental part of their role. Though HVs may be motivated to provide support, the capacity, capability and motivation needed to deliver LVs are compromised by environmental factors including a diminished workforce, conflicting priorities and inadequate training and support. Many suggestions have been made regarding the modifications that are needed to improve assessment, interventions, outcomes, pathways and collaborative, integrated care.

The uncertainty and confusion regarding the content and purpose of LVs has led to variations in practice that extend from the avoidance of delivering any kind of support to the delivery of multi-component interventions. It is possible that LVs, as an intervention, has now entered what Bauman et al (1991) describe as the 'zone of drastic mutation' whereby confusion about what they are compromise both delivery and effectiveness.

The fundamental message from this survey is that HVs do want to have a better shared understanding of what they can do to identify and support mothers with MHPs but they also want to be confident that they are practising within the limits of their professional remit and that what they are doing is informed by evidence from research and practice. No HV should be expected to deliver care that they have not been trained to provide, especially in the arena of mental health, because of the potentially adverse repercussions for both families and HVs. The frequently repeated survey respondents' request for better training needs to be heard.

HVs have also made it very clear that they need a supportive infrastructure that endorses the optimal and seamless provision of care across professions and organisations and recognises the importance of protecting and promoting the emotional wellbeing of all health professionals who, in turn, are responsible for detecting and treating maternal MHPs. The commitment to interprofessional care needs to be evident in the way that policies are formulated, services are commissioned, protocols and pathways are designed and how training is devised and delivered.

7.8. Chapter summary

Moules (2002) in her exposition of hermeneutic inquiry refers to Gadamer's proposition that 'the harmony of all details with the whole is the criterion of correct understanding' and that 'failure to achieve this harmony means that understanding has failed' **(GADAMER, 1989 CITED IN MOULES, 2002 P.16)**. Harmony implies an understanding of differing viewpoints that allow agreement about the whole. Each chapter has explored a different part of the conundrum that is LVs. This chapter represents the final stage in the exploration of the multiple influences, perspectives and outcomes that might have a bearing on what HVs do to support mothers with MHPs. An examination of current practice is an essential part of the jigsaw. It is not possible to make evidence-informed recommendations about the role of HVs in supporting mothers with MHPs without paying attention to the perceptions and experiences of HVs. I like Lomas's analogy that an emphasis on research and policy without due regard for the perspectives of clinicians is comparable to the sound of one hand clapping **(LOMAS, 1997)**.

What is needed is an integration of different viewpoints to come up with a solution that is compatible with the multiple factors and demands that determine the priorities, power and motivation of the 'actors' involved in the provision of care. Van de Ven and Johnson (2006) refer to the importance of 'engaged scholarship' whereby researchers, policy makers and clinicians get to-gether to share their perceptions of a particular issue, and how it should be addressed, so that areas of dissent can be explored and resolved. It would be advantageous to consider the views of the other 'actors' (policy-makers, commissioners, managers, other clinicians) to explore their perceptions of the relevance and importance of LVs. As that is not possible due to the limitations of time and opportunity, an assumption has been made that a first step towards 'harmony' is to provide greater clarity about what research, theory and HVs themselves suggest, is appropriate and possible for HVs to do.

The final stage in the re-design of the LV intervention is therefore to combine evidence from theory and research (Chapters 4,5 & 6) with evidence from practice (this chapter) and present these findings to a group of expert HVs in order to establish the components of an effective intervention that is clearly described, feasible to deliver, acceptable to HVs and perceived by HVs as acceptable to mothers. This is the subject of the next chapter.

Chapter 8. Modelling Process and Outcomes

8.1. Introduction

Modelling process and outcomes is the sixth stage in the enriched development phase of the MRC guidance for developing and evaluating complex interventions developed by Bleijenberg et al (2018). 'A model is a representation of select aspects of reality in a simplified way' **(DAHABREH ET AL, 2016 P.2.)**. In this context modelling refers to hypothetically testing the plausibility of the constituent parts of the proposed HV intervention.

Involvement of practitioners in the translation of evidence into practice helps to overcome resistance to change. Opportunities for exploration and discussion of new ideas or different ways of working can help to ensure that a re-designed intervention is compatible with practitioners' professional ethos and resonates with their personal beliefs about interventions that are likely to be feasible and effective **(RYCROFT-MALONE, 2013)**. The method used to involve HVs was a real-time, modified, technological Delphi approach.

According to Williams & Bedas (2018), Self Determination Theory **(RYAN & DECI, 2017)** helps to explain how a health professional's sense of autonomy, competence and self-relatedness promotes internally regulated (rather than externally imposed) motivation. Autonomy refers to the ability to act in a way that is congruent with professional/personal values; competence refers to the sense of having the necessary skillset to perform a task; and relatedness refers to the sense of being connected to a larger professional/social group (doing what everybody else does) **(RYAN & DECI, 2017)**.

If an intervention is to be implemented, sustained and effective, practitioners need to believe that it is the right thing to do, rather than something that they have to do in order to comply with an externally imposed agenda. 'Disagreement with the evidence, negative beliefs about the usefulness or added value of the intervention or belief that the intervention was not part of their role' was a frequently described barrier to implementation in a systematic review exploring the evidence to practice gap in primary care **(LAU ET AL, 2016 P.33.)**. Some of these issues have been highlighted in previous chapters with respect to the support that HVs provide to mothers with MHPs.

The end goal of intervention adaption or development is real-world implementation **(O'CATHAIN ET AL, 2019)**. Perceptions of acceptability (to HVs), feasibility (for HVs) and appropriateness (to HVs and mothers) therefore provide a useful indication of whether an intervention is likely to be adopted and sustained in clinical practice and will culminate in anticipated outcomes **(PROCTOR ET AL, 2011)**.

The rest of this chapter elaborates on the aim and objectives of this stage of the research; the reasons for the selection of the Delphi technique as an appropriate method for this stage of the research; how and why the traditional Delphi technique has been modified; the process for voting on the proposed elements extracted from the previous stages of research; the results and implications of the voting outcomes; the strengths and limitations of the Delphi Approach used in this study; and the reactions of the expert group of HVs to the integration of the findings from this stage of the research into a prototype 'manual' designed to inform HV perinatal mental health practice.

The principles enshrined in the guidance on 'Conducting and Reporting Delphi Studies' (CREDES) developed by Jūnger et al (2017) were used to inform the design and reporting of the study findings.

8.2. Aim and objectives

Aim: To update the LV intervention offered by HVs based on evidence of feasibility, acceptability and effectiveness.

OBJECTIVES:

- To present the potential components and clinical activities derived from the literature reviews and survey of HVs to a group of expert health visitors, in order to seek consensus regarding the components that should be included in a health visitor-led intervention;
- To produce a draft manual to guide health visiting perinatal mental health practice.

8.3. Method

The Delphi method was originally developed as a systematic forecasting method used by the military **(DALKEY & HELMER, 1963)**. The central premise of the Delphi method is the use of experts to generate consensus when there is insufficient or conflicting evidence and diverse opinions about the best course of action to take **(FLETCHER & MARCHILDON, 2014)**. The survey findings indicated that this was the case with LVs.

Delphi studies usually commence with the generation of categories or questions by a group of experts or from a systematic review of the literature or other sources of evidence. These items are then sent to an identified group of experts (via mail or email) who score or rank the items. The researcher collates the returned responses and then sends the ranked/scored items back to each of the experts so that they can see how their response compares to the aggregated responses from the rest of the expert panel. This exercise is repeated over a predetermined number of rounds or until a pre-specified level of consensus is reached **(WILLIAMS & WEBB, 1994)**. The optimum number of rounds required to maintain engagement of participants is 2 - 3, with 2 rounds considered sufficient when the items are prepared in advance by the researcher e.g. from literature reviews **(TREVELYAN & ROBINSON, 2015)**. Items for consideration in this Delphi approach were generated as a result of a review of the literature and the survey of HVs and therefore 2 rounds of voting were considered sufficient.

In conventional Delphi studies, it is generally believed that collecting anonymised data from geographically dispersed group of experts provides a better indication of collective opinion than if the experts were assembled in one place where the strongest voices might prevail **(KEENEY ET AL, 2011)**. The challenge, in either scenario, lies in embracing individual opinions whilst at the same time moving towards consensus. Personal interest in the participants from the researcher may enhance motivation and prolong engagement. McKenna (1994), who used one-to-one interviews in the first round of a Delphi study, felt that nurturing the relationship with the participants increased the likelihood of ongoing commitment. In non-real-time, non-face-to-face studies involving several rounds of participant involvement there are often high attrition rates, so the benefit of feedback is lost **(TREVELYAN & ROBINSON, 2015)**. Providing an opportunity to discuss rather than ignore disagreements may help to retain dissenters and avoid the creation of artificial consensus amongst the remaining panellists **(FLETCHER & MARCHILDON 2014; BRADY, 2015)**. For autonomous practitioners, such as HVs, who also have a strong sense of professional identity there are potential benefits to be gained from gathering HVs together in one place to enable them to share individual insights and wisdom, whilst also promoting a sense of collective endeavour **(KEENEY ET AL, 2011; MCKENNA, 1994)**.

Face-to-face meetings with a group of expert HVs was therefore the chosen method of engagement for this Delphi Approach. The expertise of the HV experts was denoted by their accreditation as iHV PIMH champions. This means that they have all received and delivered training in PIMH and are regarded as place-based leaders who advocate for continuous quality improvement in services and outcomes for families affected by perinatal mental ill-health. Face-to-face meeting compromises the anonymity of the participants. Using an audience response voting system provided partial anonymity in that the HVs knew who was at the meeting but did not know how they had voted.

Some of the challenges encountered in conducting a conventional Delphi study include how to decide on the size and composition of the 'expert' group; the potential for the production of an unmanageable number of items if these items are generated by the participants; limited opportunities for critical exploration of participants' expectations of the outcome; participant uncertainty regarding whether their contribution will make a difference; variable interpretation by the participants of the items under consideration with limited or no opportunities for clarification and discussion; lack of individual accountability for the views expressed that might predispose to poorly considered or flippant contributions; the delay between rounds of responses that can undermine motivation and participation; and concern that the process stifles innovation and potentially leads to an outcome that represents conformity to the norm rather than the 'best' or future-oriented option **(GOODMAN, 1987; FOTH ET AL, 2016).**

Iqbal & Pipon-Young (2009, p.599) suggest that 'the primary function of the Delphi method is to explore an area of future thinking that goes beyond the currently known or believed.' This was also why the Delphi approach was chosen in preference to a nominal group technique. The latter method is a process for brainstorming the ideas and recommendations of a group of experts. The risk is that consensus achieved using a nominal group technique will advocate continuation of existing practice rather than the incorporation of innovative ideas and evidence from research.

Linstone and Turoff (2011) propose that the Delphi approach is a structured communication process designed to facilitate collaborative learning rather than to force consensus. It has been argued that 'awareness raising and the collective and consultative process itself is equally or possibly even more important than the outcome' **(GUZYS ET AL, 2015 P.11)**. From a Gadamerian philosophical perspective the purpose of the Delphi method is to acknowledge divergent views, facilitate reflection, develop insight and generate new understanding so that the end result represents a 'fusion of horizons' between the researcher, the existing literature and the panel of experts **(GUZYS ET AL, 2015 P.11).**

Delphi panels vary in size. Keeney et al (2011) suggest that 15 – 30 participants from the same discipline constitute a sufficient number to generate meaningful consensus. More than 30 participants do not seem to improve the quality of the results. Whilst there are variations in the definition of consensus, the expectation is usually that at least 70% of Delphi participants concur that the item (whatever it is) should be included **(DIAMOND ET AL, 2014)**. This was the threshold used in this study. Morgan & Jorm (2009) in their Delphi consensus study to identify self-help strategies for the treatment of depression wanted to find out not only how helpful the strategy might be but also how easy it was to do, as there are often discrepancies between beliefs about what is desirable to do and what is actually possible to do, given the constraints of capacity, motivation and context. The group of expert HVs participating in this study were therefore invited to vote on the likelihood of HVs incorporating the proposed elements into an HV intervention as well as their perception of the acceptability of the proposed elements to mothers. The perceptions of HVs of the acceptability to mothers of the proposed components of the intervention is

used as a surrogate measure of maternal acceptability, in the absence of adequate time and opportunity to identify, recruit, and consult, with mothers themselves.

As the exploration of the needs of providers and recipients (Chapter 6) revealed a lack of understanding about the role and skillset of the HV as well as the assessment process and eligibility for an HV intervention, the elements that were presented to the expert HVs included the continuum of perinatal mental health care from the first encounter to the components that could be included in an intervention.

The limitations of the collective wisdom generated during a Delphi exercise include the transferability of the findings to real-world contexts. On completion of the Delphi method, the cogency and plausibility of the intervention components agreed by the expert panel were therefore shared with other HVs in their respective workplaces in order to explore the relevance and acceptability of the proposed manualised intervention.

8.3.1. Ethical considerations

The study was approved by the Faculty of Health and Life Sciences ethics committee at Oxford Brookes University (FREC study number 2014/58).Ethics approval for this section of the study was granted by the chair of the ethics committee and added to the original ethics approval. Details of the Delphi approach were explained to the participants during the course of a face-to-face meeting. All participants were provided with participant information sheets and required to sign a consent form (see appendix 3)

8.3.2. Participants

An established group of expert HVs (n = 27) were recruited to participate in a collaborative, systematic consideration of the conceptual framework and the potential constituent elements of the proposed model of care (the re-designed LV intervention). Given the potential for extenuating circumstances that might prevent HVs from attending all of the scheduled meetings, some flexibility had to be built in to what might be considered an acceptable number of participants. As Keeney et al (2011) suggest that 15-30 Delphi participants are sufficient to acheive meaningful outcomes, quorum was set at 20 participants (to allow for attrition).

8.3.3. Data collection

Over a period of six 2 hour face-to-face meetings distributed over 18 months between Jan 2016 and June 2017, the expert group of HVs were introduced to the study and presented with powerpoint slides containing summary information regarding the potential components of feasible, acceptable and effective interventions derived from the literature reviews and survey (Table 8.1).

TABLE 8.1. POTENTIAL COMPONENTS OF A HV PERINATAL MENTAL HEALTH INTERVENTION EXTRACTED FROM THE LITERATURE REVIEWS AND SURVEY OF HVS (PREVIOUS STAGES OF PHD STUDY)

TOPIC	FINDINGS EXTRACTED FROM LITERATURE REVIEWS AND SURVEY OF HVS
Therapeutic Relationship	HVs need to provide clear information about their expertise and capacity to provide appropriate and effective support, tailored to the needs and circumstances of mothers. Health visitors need to be mindful of the fundamental principles that underpin all therapeutic encounters. HVs need to provide clear information regarding the purpose, duration and frequency of the intervention. HVs need to be mindful of how difficult it can be for mothers to share how they really feel. HVs need to be mindful about how their actions and words might be interpreted by emotionally fragile mothers.
Psychoeducation	Health visitors need to raise awareness about the range of MHPs, the process and potential outcomes of assessment and the sources and type of help that are available, as well as provide anticipatory guidance about what to expect, and how to cope, with pregnancy, birth and infant care.
Assessment (including psychosocial assessment)	Sensitive assessment has many facets, is an on-going process, and needs to be integrated with the intervention. Health visitor assessments and interventions need to acknowledge the multiple factors that affect the physical and mental health of mothers. Sensitive and comprehensive assessment provides the foundation for appropriate, acceptable and effective care. As prevention and early intervention are the primary focus of health visiting practice, health visitors should seek to identify and ameliorate symptoms causing psychological distress (psychosocial assessment).
Intervention	As a psychosocial intervention, the purpose of LVs should be to both prevent and treat MHPs. Non Directive Counselling on its own is not always acceptable to mothers or HVs and may not be sufficient to overcome maternal psychological distress. Multi-component interventions should include 'active listening,' collaborative problem solving, formulation of mutually agreed goals, and behavioural activation. Any intervention must include strategies to enable the mother to restore and maintain her physical and emotional well-being. Helping mothers to negotiate relationships and activate support networks should be an integral component of an HV-led intervention. Relationships between mothers and others are of fundamental importance whether it is past relationships with parents, current relationships with the foetus and partner, or future relationships with the infant, the partner, family and social networks. Consideration must be given to the actions or experiences that promote happiness, resilience and well-being. Modification of lifestyle factors can improve mental health. Blended interventions combining face-to-face encounters with telephone contact and/or smartphone or internet-based assessments, activities and peer support may improve outcomes. The structure, content and purpose of the HV intervention needs to be clearly described.
Outcomes	Additional or alternative outcome measures need to be developed that reflect maternally determined goals, clinically significant outcomes and the impact of maternal mental ill-health on all members of the family.

The first meeting was an introductory session to explain the purpose of the research, provide participant information sheets and secure written consent (see appendix 3). Meeting 2 was inquorate as only 13 HVs attended. Meetings 3 - 4 provided opportunities for voting, meeting 5 was for presentation of the findings of the two rounds of voting to the group (Table 8.2). Following meeting 5, the findings from the voting process were integrated into an assessment and intervention framework formatted as a scripted guide for practice. The expert HVs were given two months to review the guide and then return at meeting 6 to give informal feedback regarding the clinical utility and relevance of the guide, in the form of informal comments.

TABLE 8.2. DELPHI APPROACH MEETINGS

DATE OF MEETING	DELPHI APPROACH ACTIVITY
Wednesday 2nd February, 2016 (n=27)	Information provided (participant information sheets) and consent forms signed.
Tuesday 17th May, 2016 (n=13)	Meeting inquorate.
Tuesday 1st November, 2016 (n= 23)	Round 1 of voting.
Thursday 19th January, 2017 (n = 27)	Round 2 of voting.
Tuesday 25th April, 2017 (n = 24)	Presentation of draft assessment and intervention framework.
Thursday 27th June, 2017	Feedback from expert group regarding utility of framework.

In the first of the meetings when voting took place, HVs were each given a notebook to record any comments they would like to make about the format and the content of the Delphi process, or missing items, in an attempt to overcome the limitations imposed by the lack of anonymity and non-participant generation of items. The non-attributable comments were collated by the researcher and re-presented at the subsequent meeting.

During meetings 3 & 4, Delphi delegates voted on potential intervention components using audience response voting pads. The potential components that informed the content of the powerpoint presentations are summarised in table 8.1. Turning Point technology software was used to link questions within the powerpoint slides to audience response voting pads.

8.3.4. Data analysis

Responses to the questions posed were automatically recorded as frequency distributions by the Turning point technology software. Comments made in the notebooks were collated and incorporated into the powerpoint presentations/questions at subsequent meetings. The researcher kept a research diary recording salient aspects of discussions and reflections on the Delphi process. Written feedback at the final session regarding the utility of the guide for practice was tabulated.

8.4. Results

Four of the 27 HVs who agreed to participate in the study were not able to attend the first session, so the number of HVs participating in the Delphi approach was 23 in round 1 and 27 in round 2. The results are presented in a series of bar charts to indicate the voting options and the distribution of the votes. Consensus was pre-set at 70% **(DIAMOND ET AL, 2014)**. This equated to 16+ votes in round 1 and 19+ votes in round 2. All the questions allowed multiple selections apart from the question about the number of visits. In round 2, delegates were given the option to review the elements that did not reach the consensus threshold in round 1 and choose whether they would like them to be included in the second round. A supplementary question exploring the likelihood of implementation and perceived acceptability to mothers, of the agreed elements, followed each question. There was insufficient time in round 1 for the delegates to vote on the content of the intervention, so this was deferred to round 2. (See Table 8.3a and b for rounds 1 and 2 of the Delphi Approach).

TABLE 8.3A - B DIAGRAM SUMMARISING FLOW OF THE DELPHI APPROACH

TABLE 8.3A ROUND 1 OF THE DELPHI APPROACH

TOTAL NO OF DELPHI DELEGATES WHO CONSENTED TO TAKE PART IN THE STUDY = 27

NUMBER OF QUESTIONS PRESENTED TO DELPHI PANEL N = 17

ROUND 1 NO. OF DELEGATES = 23

QUESTION	NO OF ELEMENTS WITHIN QUESTION	NO OF ELEMENTS REACHING 70% CONSENSUS	PERCEPTIONS OF RELEVANCE REACHING 70% CONSENSUS			
			SHOULD DO	FEASIBLE TO DO	PROBABLY DO	ACCEPTABLE TO MOTHERS
Elements of HV introduction	9	6	Y	N	N	Y
HV traits	10	9	-	-	-	-
Psychoeducaton	7	1	-	-	-	-
Pre-assessment information	5	4	-	-	-	-
Psychosocial assessment	-	-	Y	Y	N	Y
Timing of comprehensive assessment	8	1	-	-	-	-
Perceptions of relevance of compre-hensive assessment	-	-	Y	N	N	Y
Assessment of emotional well-being	6	0	-	-	-	-
No. of visits	7	0	-	-	-	-
Content of 1st visit	10	5	N	N	N	N

TABLE 8.3B ROUND 2 OF THE DELPHI APPROACH

	ROUND 2 NO. OF DELEGATES = 27					
	NO. OF ELEMENTS REACHED CONSENSUS FROM ROUND 1 (+ THOSE RETAINED AT REQUEST OF DELEGATES)	NO OF ELEMENTS REACHING 70% CONSENSUS	PERCEPTIONS OF RELEVANCE REACHING 70% CONSENSUS			
QUESTION			SHOULD DO	FEASIBLE TO DO	PROBABLY DO	ACCEPTABLE TO MOTHERS
Elements of HV introduction	6 (+1)	5	Y	N	N	Y
HV traits	9 (+1)	9	-	-	-	-
Psychoeducaton	1 (+2)	3	-	-	-	-
Pre-assessment information	4 (+1)	5	Y	Y	N	Y
Timing of comprehensive assessment	1 (+2)	3	-	-	-	-
Perceptions of relevance of comprehensive assessment	-	-	Y	Y	N	Y
No. of visits	0 (+7)	0	-	-	-	-
Content of 1st visit	5 (+3)	6	Y	Y	N	Y
Elements to be included (pt. 1)	9	4	-	-	-	-
Elements to be included (pt. 2)	9	8	-	-	-	-
Likelihood of including CBT techniques	-	-	N	Y	N	N
Likelihood of including lifestyle elements	-	-	N	Y	Y	Y

In round 1, the delegates were given exercise books to allow them to make additional anonymised comments and suggestions. The exercise books were collected at the end of the session and the content is summarized in table 8.3. Appropriate suggestions were incorporated into the second round of voting. For example, a suggestion was made to include the antenatal visit and the 7-12 month assessment as optimal times for a comprehensive assessment of maternal mental health. These options were offered in round 2.

TABLE 8.3. ANONYMOUS VERBATIM COMMENTS MADE IN THE EXERCISE BOOKS BY DELPHI DELEGATES

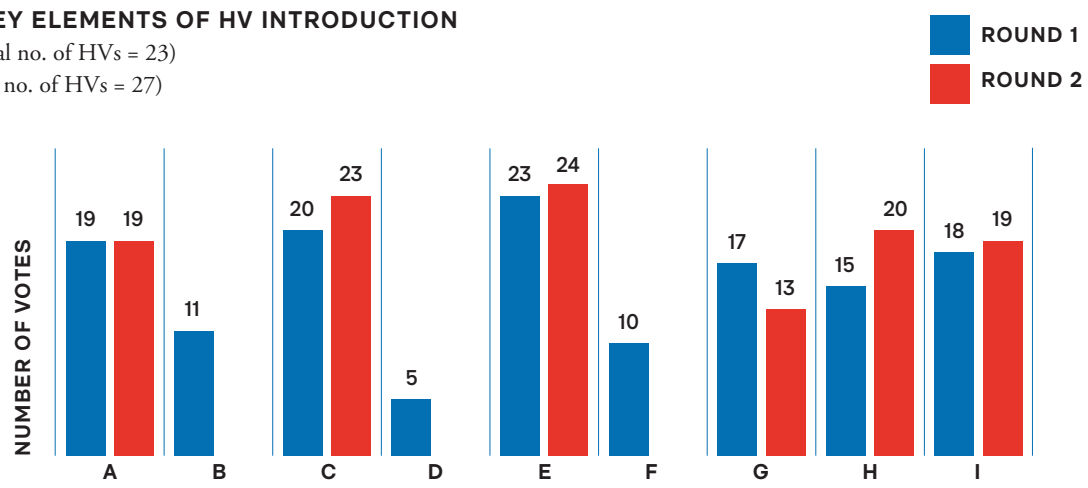
TOPICS RAISED	COMMENTS
When to assess	a/n, birth +1yr, 10 – 16 weeks, 6-12-month developmental check, need to have a specific time for comprehensive assessment, otherwise it might not get done at all.
Assessment process	What tools should be used, especially for culturally diverse populations. Whooley questions not satisfactory, should encourage use of Boots well-being plan.
Number of visits	Need to be flexible, time a barrier, 2+ 6 was Jenni Holden model.
Components of LVs	Nutrition and physical well-being are important. Need to emphasise that psychoeducation in antenatal visit is key component of HV role. Are alternative options such as art therapy, peer support included in HV role?
Partners	Need to involve/assess partners.
Role clarity	Clarity of HV role needed, concern about delegation of LV's to skill mix
Supervision	Supervisors also need to have appropriate competencies
IAPT	Barrier to accepting that other professionals capable of offering interventions. IAPT do not have baby/child policy – maybe get rid of IAPT and give funding to HVs!
Outcomes	Maybe use PROMS – patient reported outcome measures at the start and end of the intervention.
Terminology	Different terms used to describe the same thing – confusing!
Priorities	KPI is king!
Training	Different HVs have different amounts and types of training. Maybe need to think about using techniques like readiness to change, motivational interviewing, or return to the skilled helper model. What do student HVs get in their training?
Naming the intervention	LVs as a term is not recognized by commissioners, so maybe call them something else – may help with commissioning the service.

8.4.1. The voting proccess

8.4.1.1. QUESTION: WHAT DO YOU THINK ARE THE KEY ELEMENTS THAT HVS SHOULD INCLUDE WHEN INTRODUCING THEMSELVES FOR THE FIRST TIME?

Surveys of mothers reveal that they often don't understand the role of the HV **(SHAKESPEARE ET AL, 2006; SLADE ET AL, 2010)**. If given this information, mothers are more likely to trust HVs and disclose sensitive thoughts and feelings. Delphi delegates were therefore asked to vote on the information that they thought HVs should share with mothers at the first point of contact to ensure that mothers were aware of their professional remit and parameters of, and limits to, confidentiality (Fig 8.2).

FIG 8.2 - KEY ELEMENTS OF HV INTRODUCTION
(Round 1 - total no. of HVs = 23)
(Round 2 total no. of HVs = 27)



QUESTION 1

WHAT DO YOU THINK ARE THE KEY ELEMENTS THAT HVS SHOULD INCLUDE WHEN INTRODUCING THEMSELVES FOR THE FIRST TIME?

A.	Qualified nurse with 1 year additional training.
B.	Primary focus is the health, development, well-being and safety of all children under 5.
C.	Concerned with health and wellbeing of all family members.
D.	Especially mothers.
E.	Have been trained in aspects of both physical and emotional well-being so mothers can talk to them about anything that they are worried about.
F.	As nurses they are registered with the NMC and are therefore bound by a code of conduct and a duty of care.
G.	They work as part of the primary heath care team and have connections with Children's Centres.
H.	Anything that mothers say will be treated in strictest confidence unless there is a risk of harm.
I.	HVs will always share with mothers what they are doing and why.

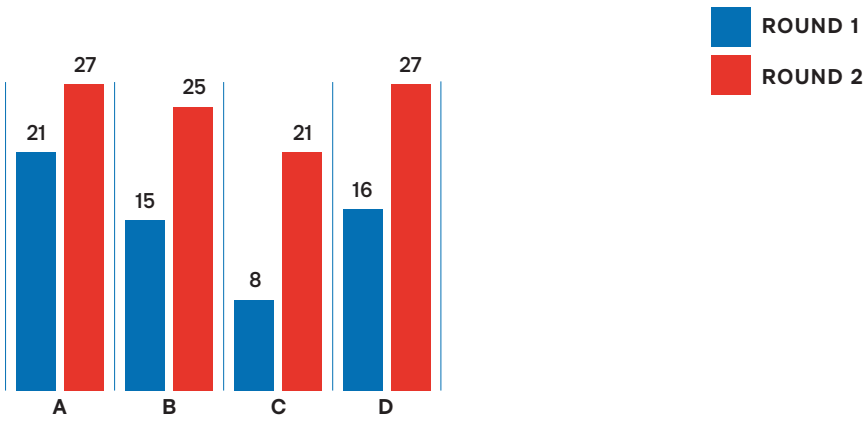
Three items (B.D.& F Fig 8.2) failed to reach the 70% consensus threshold (16+ votes) in round 1. HVs in the second round agreed that these 3 elements should be excluded. The item about confidentiality (item H) did not surpass the 70% threshold in round 1, but the delegates felt that it should be included in the voting in round two. This item secured 20 votes in round 2, surpassing the 70% threshold of 19 votes. Item G, about membership of the primary health care team and connections with Children's Centres surpassed the 70% threshold in round 1 but did not in round two.

Delphi delegates therefore agreed, after 2 rounds of voting, that the key elements of the HV introduction are that HVs are qualified nurses with additional training; are concerned with the health and well-being of all family members; have been trained in aspects of both physical and emotional well-being and mothers can talk to them about anything that they are worried about; anything that mothers say will be treated in strictest confidence unless there is risk of harm; and HVs will always share with mothers what they are doing and why.

The perception that something is the right thing to do does not mean that it is always possible to deliver in practice. HVs were invited to indicate whether they thought HVs *should* provide the level of information agreed in the previous consensus exercise, whether it was *feasible* to do, whether it was *probable* that they would, and whether they thought that the agreed elements would be *acceptable to mothers* (Fig 8.3).

FIG 8.3 - PERCEPTION OF RELEVANCE OF ELEMENTS OF INTRODUCTION

(Total no. HVs in round 1 = 23
(Total no. of HVs in round 2 = 27)



QUESTION 2

PROVIDING CLEAR INFORMATION ABOUT HV ROLE…

A. I think HVs should provide this level of information.

B. I think it is feasible for HVs to do this.

C. I think it is probable that HVs would do this

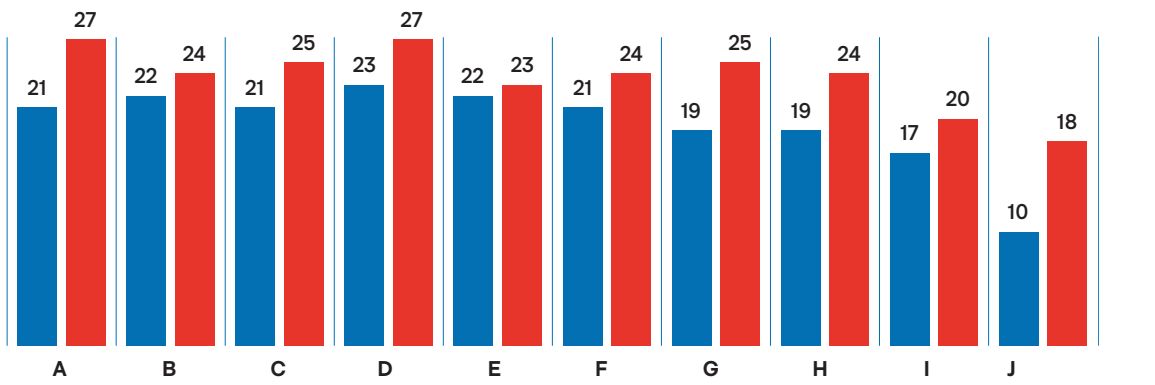
D. I think this would be acceptable to mothers

In the first round, the majority of the delegates (21/23) voted that the agreed elements should be included in the introductory information given by HVs to mothers, at the first point of contact. Although the 70% threshold of 16+ votes in the first round was just reached for the acceptability to mothers of these elements, less than 70% of delegates voted that it was feasible or probable that HVs would be able to deliver on this expectation. However, in round 2, all delegates voted that HVs should include the agreed elements and that they would be acceptable to mothers with the 70% threshold also breached for feasibility and probability.

8.4.1.2. QUESTION: WHICH OF THESE TRAITS SHOULD BE SPECIFIED AS ESSENTIAL FOR HVS?

The evidence synthesis of the views of mothers (Chapter 6) indicated that they perceived that some health professionals appeared brisk, rushed and busy. The foundation for effective therapeutic relationships is the skills and qualities of the professional providing the support **(WAMPOLD & IMEL, 2015)**. HVs have to give the impression that they are both knowledgeable and approachable, have the time to listen and are willing to help. Delphi delegates were invited to vote on the traits that they thought HVs needed, to be able to work effectively with mothers with MHPs (Fig 8.4).

FIG 8.4 - HV TRAITS
(Total no. of HVs in round 1 = 23)
(Total no. of HVs in round 2 = 27)



QUESTION 3

WHICH OF THESE TRAITS SHOULD BE SPECIFIED AS ESSENTIAL FOR HVS?

A.	Demonstrate warmth and acceptance.
B.	Employ a non-judgemental approach
C.	Show genuine interest and empathy
D.	Create a relationship based on trust
E.	Preserve client's dignity, autonomy and self-respect
F.	Maintain confidentiality
G.	Show compassion
H.	Communicate a willingness to help
I.	Tolerate uncertainty and ambiguity
J.	Maintain a sense of humour, humility and curiosity

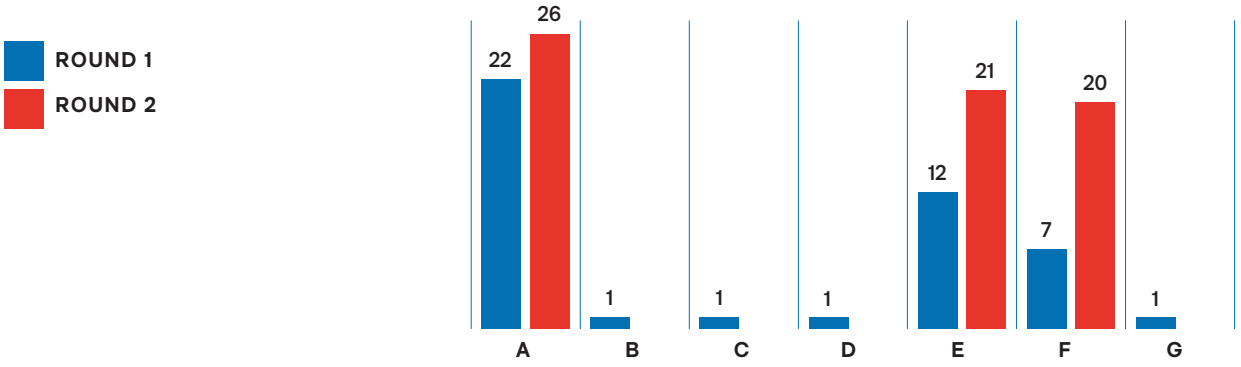
The only item that did not breach the 70% consensus threshold in round 1 was item J – *'maintain a sense of humour, humility and curiosity.'* The majority view of the group was that this item should be retained for re-voting in the second round. Although 8 more people voted for this trait, this was still not enough votes to breach the 70% consensus threshold in round 2.

8.4.1.3. QUESTION: WITH REGARD TO PROVIDING ANTICIPATORY INFORMATION ABOUT COMMON PERINATAL MHPS . . . ?

The evidence synthesis of the views of mothers (Chapter 6) confirms the finding from the modified distillation and matching model process (Chapter 4) that mothers want anticipatory information about what to expect, and how to cope, in terms of the transition to parenthood and the potential impact this may have on their mental health (psychoeducation). Delphi delegates were asked to indicate if and when they provided this information to mothers (Fig 8.5).

FIG 8.5 - PSYCHOEDUCATION

(Total no. of HVs in round 1 =23
(Total no. of HVs in round 2 = 27)



QUESTION 4

WITH REGARD TO PROVIDING ANTICIPATORY INFORMATION ABOUT COMMON PERINATAL MENTAL HEALTH PROBLEMS.

A.	I do this routinely with all mothers I see antenatally.
B.	I do it with some mothers if I have the time.
C.	I'm not sure that it is necessary
D.	Sometimes there just isn't a good time to bring it up.
E.	I talk about mental health at the new birth visit.
F.	I talk about the sorts of problems that can affect some mothers when I arrange to go and see them for the 6-8 week assessment.
G.	I don't do it

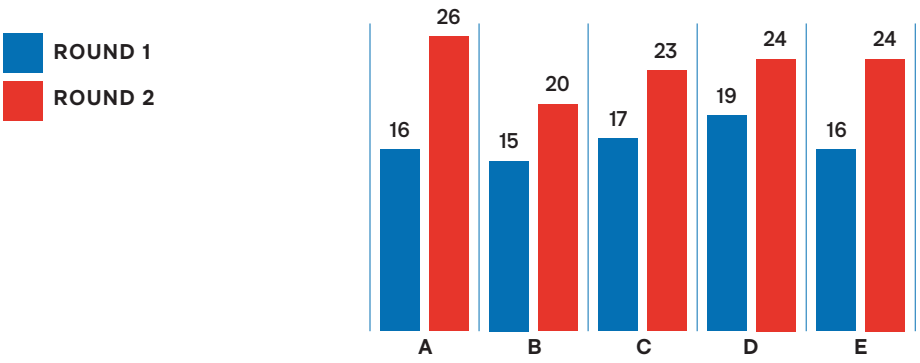
The results of the voting indicate that the majority of the delegates routinely talk about common MHPs at the antenatal contact. Although less than 70% of delegates in round 1 indicated that they talked about common MHPs at the new birth visit and the 6-8 week check, delegates wanted the opportunity to vote again on these options. Consensus was reached in round 2 indicating that the majority of HVs provided anticipatory information about common MHPs on these three occasions.

8.4.1.4. QUESTION: WHAT INFORMATION DO YOU THINK HVS SHOULD PROVIDE IN PREPARATION FOR ASSESSMENT OF MATERNAL MENTAL HEALTH STATUS?

In a systematic review and meta-synthesis of the acceptability of screening for postnatal depression, women preferred to be notified in advance about the screening process; preferred to be assessed in a familiar setting by an engaged and empathetic health professional; and preferred the opportunity for verbal feedback and discussion rather than just a summary of the test 'score'. **(BREALEY ET AL 2010)**. The full evidence underpinning the updated NICE guideline for antenatal and postnatal mental health emphasizes the importance of providing information to women about the prevalence and nature of MHPs; how and why they may be affected by mental health issues; the process of assessment in terms of when and how formal and informal assessments of mental health might take place; what will happen as a result of an assessment; the range of options of support that are available; and that some women are concerned about losing custody of their baby if they disclose how they feel but this is very unlikely to happen **(NCCMH 2014)**. Delphi delegates were therefore asked what information they expected to provide to mothers in preparation for an assessment of maternal mental health (Fig 8.6).

FIG 8.6 - PRE-ASSESSMENT INFORMATION

(Total no of HVs in round 1 = 23)
(Total no. of HVs in round 2 = 27)



QUESTION 5

WHAT INFORMATION DO YOU THINK THAT HVS SHOULD PROVIDE IN PREPARATION FOR ASSESSMENT OF MATERNAL MENTAL HEALTH STATUS?

A. HV knowledge and skills in maternal mental health.

B. Prevalence and range of MHPs.

C. Timing and nature of assessment and what will happen next.

D. Range of treatment options available.

E. Allaying fears about mothers losing custody of the baby.

Although the results from the first round were not so convincing, results from the second round of voting surpassed the 70% threshold for all elements of pre-assessment information Implying that the majority of delegates agreed that mothers should be given information about the relevant knowledge and skills of the HV; the prevalence and range of MHPs that mothers might experience; the timing, nature and potential outcomes of assessment; the range of treatment options available; and the unlikely possibility of losing custody of the baby.

8.4.1.5. QUESTION: WITH REGARD TO UNDERTAKING A COMPREHENSIVE PSYCHOSOCIAL ASSESSMENT INCLUDING THE COMPONENTS SPECIFIED IN RECOMMENDATION 1.6.1. OF THE NICE GUIDELINE…

Recommendation 1.6.1. of the NICE guideline **(NICE, 2014A)** lists a number of vulnerability factors that might perpetuate, or precipitate, symptoms of anxiety or depression (psychosocial assessment). HVs were invited to comment on whether they thought that conducting a comprehensive psychosocial assessment was compatible with the role of the HV.

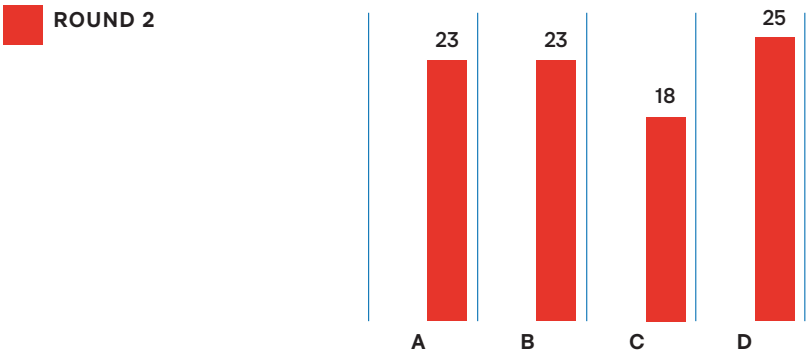
TABLE 8.4. ELEMENTS INCLUDED IN THE PSYCHOSOCIAL ASSESSMENT ADVOCATED IN RECOMMENDATION 1.6.1 IN THE NICE GUIDELINE FOR ANTENATAL AND POSTNATAL MENTAL HEALTH (NICE, 2014A).

Assessment and diagnosis of a suspected mental health problem in pregnancy and the postnatal period should include:

- history of any mental health problem, including in pregnancy or the postnatal period
- physical wellbeing (including weight, smoking, nutrition and activity level) and history of any physical health problem
- alcohol and drug misuse
- the woman's attitude towards the pregnancy, including denial of pregnancy
- the woman's experience of pregnancy and any problems experienced by her, the foetus or the baby
- the mother–baby relationship
- any past or present treatment for a mental health problem, and response to any treatment
- social networks and quality of interpersonal relationships
- living conditions and social isolation
- family history (first degree relative) of mental health problems
- domestic violence and abuse, sexual abuse, trauma or childhood maltreatment
- housing, employment, economic and immigration status
- responsibilities as a carer for other children and young people or other adults. (new 2014)

Delegates were offered the opportunity to vote on whether they thought that every mother on their caseload should be offered a psychosocial assessment, whether it was feasible to do so, whether it was probable that this would happen and whether it would be acceptable to mothers (Fig 8.7). Owing to the technical difficulties with the Turning Point software encountered in round 1, voting for this question is only available for round 2. Less than 70% of voters thought that it was probable that HVs would be able to complete a psychosocial assessment for every mother on their caseload even though they thought that HVs should and could do this, and it would be acceptable to mothers.

FIG 8.7 - PERCEPTIONS OF LIKELIHOOD OF HVS COMPLETING PSYCHOSOCIAL ASSESSMENT FOR EVERY WOMAN ON THEIR CASELOAD.
(Total no. of HVs in round 2 = 27)



QUESTION 6

WITH REGARD TO UNDERTAKING A COMPREHENSIVE PSYCHOSOCIAL ASSESSMENT INCLUDING THE COMPONENTS SPECIFIED IN RECOMMENDATION 1.6.1 OF THE NICE GUIDELINE . . .

A. I think HVs should undertake a comprehensive psychosocial assessment for all women on their caseload.

B. I think it is feasible for HV's to do this.

C. I think it is probable that HVs would do this

D. I think this would be acceptable to mothers.

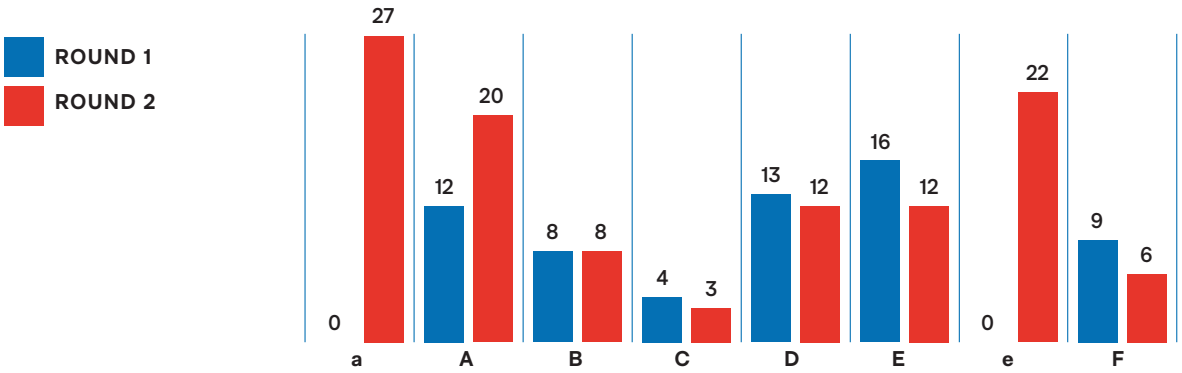
8.4.1.6. QUESTION: WHEN SHOULD HVS DO A COMPREHENSIVE MATERNAL MENTAL HEALTH ASSESSMENT?

Discussion took place regarding the content of a comprehensive maternal mental health assessment. The majority of delegates agreed that a comprehensive maternal mental health assessment would include a review of the elements of the psychosocial assessment/FHNA.
The optimal timing of a HV comprehensive maternal mental health assessment was also discussed.

The suggestions made in the exercise books given to delegates in round 1 that routine comprehensive maternal mental health assessment might also be undertaken at the HV antenatal visit and at the 6-12 month development assessment of the child were offered as options in round 2. The largest number of HVs in round 2 affirmed that these were the times when HVs were most likely to complete a comprehensive assessment of maternal mental health with the 6 week postnatal assessment also breaching the 70% consensus threshold in round 2. (Fig 8.8).

FIG 8.8 - TIMING OF COMPREHENSIVE MATERNAL MENTAL HEALTH ASSSESSMENT

(Total no. of HVs in round 1 = 23)
(Total no. of HVs in round 2 = 27)



QUESTION 7

WHEN SHOULD HVS DO A COMPREHENSIVE MATERNAL MENTAL HEALTH ASSESSMENT?

a. antenatal

A. 6 weeks postnatal

B. 8 weeks

C. 10 weeks

D. 12 weeks

E. 16 weeks

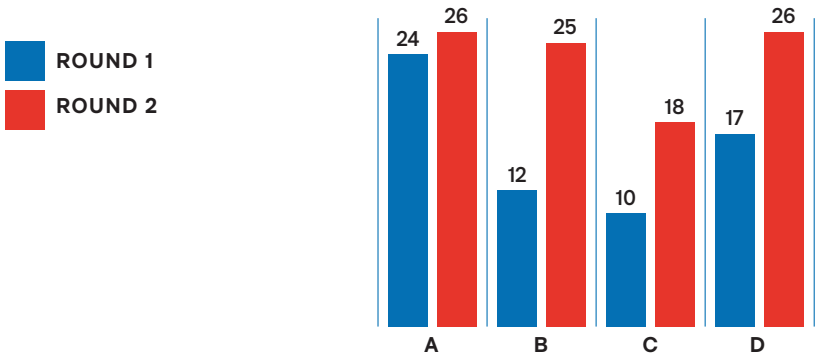
e. 6 – 12 month

F. Other

Delegates were asked to consider whether they think that all HVs should complete a comprehensive assessment of maternal mental health at the times agreed in the previous question (Fig 8.9).

FIG 8.9 - PERCEPTIONS OF RELEVANCE OF COMPREHENSIVE ASSESSMENT

(Total no. of HVs in round 1 = 23)
(Total no. of HVs in round 2 = 27)



QUESTION 8

WITH REGARD TO UNDERTAKING A COMPREHENSIVE MATERNAL MENTAL HEALTH ASSESSMENT . . .

A. I think HVs should undertake a comprehensive maternal mental health assessment at the specified times outlined in the responses above.

B. I think it is feasible for HVs to do this.

C. I think it is probable that HVs would do this.

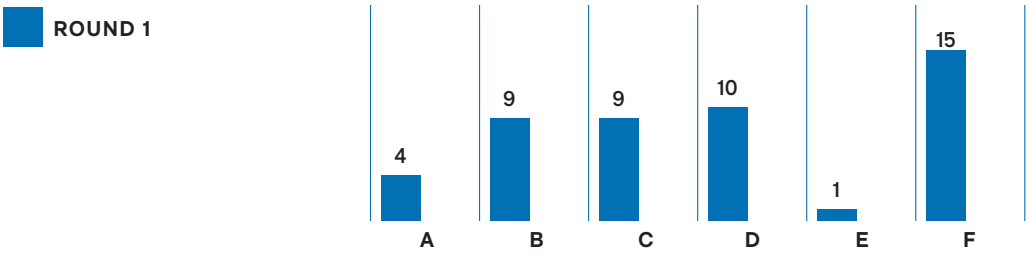
D. I think this would be acceptable to mothers.

Once again, votes reveal that whilst the majority of HVs think that undertaking a comprehensive maternal mental health assessment at the times specified is compatible with the professional remit of the HV and is acceptable to mothers, less HVs think it is feasible to deliver and less than 70% in either round think it 'probable' that this assessment will be completed.

8.4.1.7. QUESTION: IF YOU DO ASK ABOUT EMOTIONAL WELLBEING AT EVERY CONTACT, DO YOU…?

All health professionals who come into contact with mothers during pregnancy or the year after delivery are expected to assess emotional well-being at every contact **(NICE, 2014A)**. The expectation is that specific anxiety and depression identification questions are asked as part of a general discussion about a woman's mental health and well-being.

FIG 8.10 - ASSESSMENT OF EMOTIONAL WELL-BEING
(Total no. of HVs in round 1 = 23)



QUESTION 9
IF YOU DO ASK ABOUT EMOTIONAL WELL-BEING AT EVERY CONTACT DO YOU . . .
A. Use depression and anxiety identification questions.
B. Ask general questions about well-being.
C. Ask about relationships and social networks.
D. Explore possible sources of stress
E. None of the above.
F. All of the above

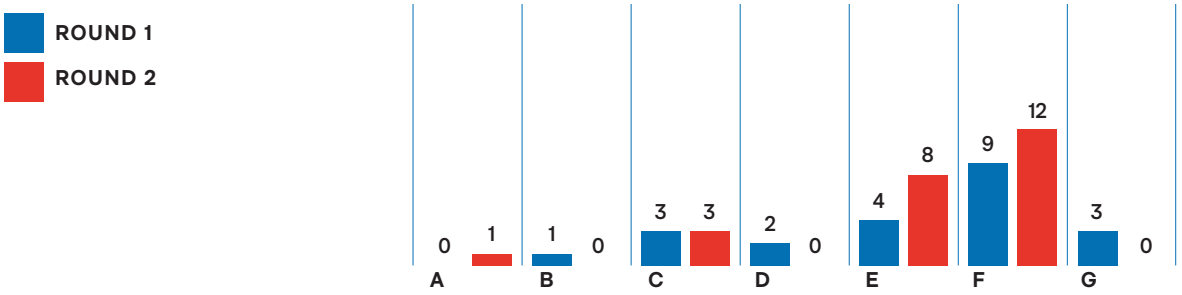
Owing to technical problems with the Turning Point software, the responses to this question in round 2 were not stored (although equally ambivalent), so only the responses from round 1 are available.
The results from round 1 indicate a lack of consensus regarding HV assessment of current mental state (Fig 8.10).

8.4.1.8. QUESTION : HOW MANY VISITS SHOULD BE INCLUDED IN A HV PACKAGE OF CARE AND HOW SHOULD THEY BE OFFERED?

The original LV protocol **(HOLDEN ET AL, 1989)** specified that the intervention should be comprised of 8 weekly, hour-long home visits. This number was also specified in the PoNDER trial **(MORRELL ET AL, 2009)**. The average number of visits actually delivered by HVs in the two intervention arms of the PoNDER trial was 4.1. At least 4 sessions are needed to confer clinically significant improvement **(DELGADILLO ET AL, 2014)**. The intervention delivered by research HVs in the RESPOND trial (Sharp et al, 2010) was based on an initial offer of 4 visits followed by review and a further 4 visits if needed. Appleby et al (1997) suggested that a realistic proposal was to offer 1 or 2 visits in the first instance to allow for a more comprehensive assessment and to provide basic support to mothers experiencing transient distress with a total of 6 visits available if needed. Based on these variations, Delphi delegates were invited to vote on the optimal number of visits that they thought should be offered to mothers with MHPs, in the first instance (Fig 8.11).

FIG 8.11 - NUMBER OF VISITS TO BE INCLUDED IN HV PACKAGE OF CARE

(Total no. of HVs in round 1 = 23)
(Total no. of HVs in round 2 = 27)



QUESTION 10

HOW MANY VISITS SHOULD BE INCLUDED IN A HV PACKAGE OF CARE AND HOW SHOULD THEY BE OFFERED?

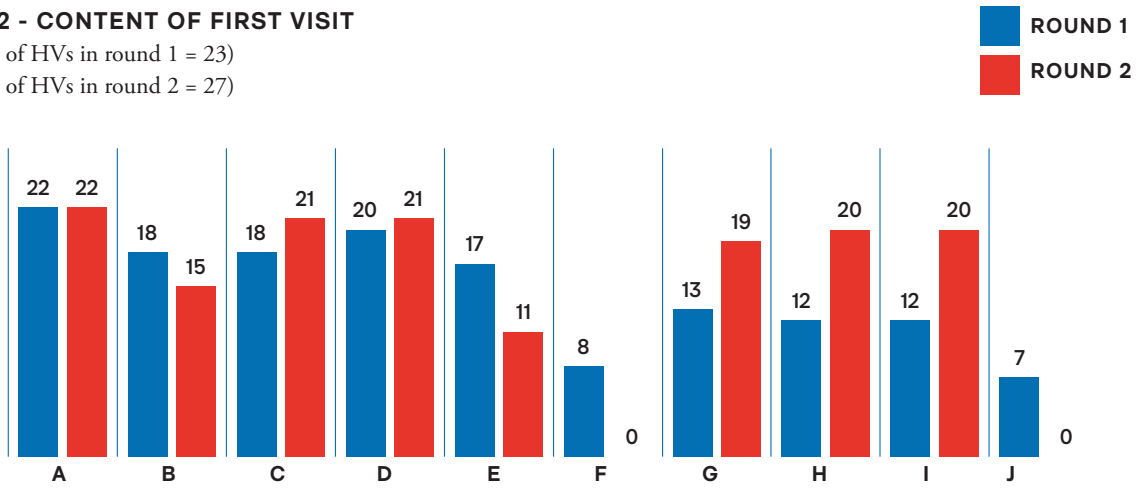
A. 8
B. 6
C. 4+4
D. 1+6
E. 2+6
F. 2+4
G. Other

Delegates could only make 1 response to this question, so although there is a trend toward the 2+4 option, the 70% threshold was not breached in either round.

8.4.1.9. QUESTION: WHAT SHOULD BE INCLUDED IN THE FIRST VISIT?

As well as providing a clear description of the role of the HV, the evidence synthesis of the views of mothers (Chapter 6) suggests that they would appreciate a clear description of what the HV intervention entails and how they are likely to benefit. Delphi delegates were therefore asked for their views on the elements that should be included in the first visit of the HV perinatal mental health intervention (Fig 8.12).

FIG 8.12 - CONTENT OF FIRST VISIT
(Total no of HVs in round 1 = 23)
(Total no of HVs in round 2 = 27)



QUESTION 11

WHAT SHOULD BE INCLUDED IN THE FIRST VISIT?

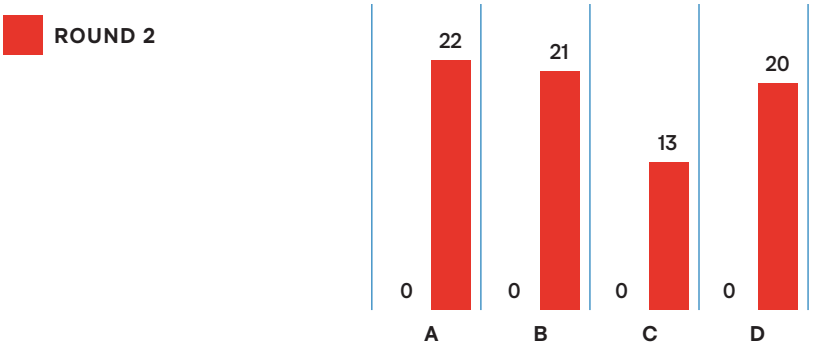
A.	Review of the reason for the package of care.
B.	Re-visiting confidentiality.
C.	Checking for specific worries/concerns about illness, circumstances or intervention.
D.	Clarification of client understanding and expectations.
E.	Review of range of options.
F.	Checking client preference for type of interaction (directive / non-directive).
G.	Tentative specification of what the package of care might include (purpose, content, frequency, duration, review).
H.	Planning for recovery (instilling hope and optimism).
I.	Agreeing format / contract for each session
J.	Discussing beginnings and endings.

The 2 elements with the lowest number of votes in the first round were 'checking client preference for type of interaction (directive/non-directive)' and 'discussing beginnings and endings.' The decision of the majority was not to include them in the second round. 'Tentative specification of what the package of care might include', 'planning for recovery' and 'agreeing the format/contract for overall package of care and for each individual session' also failed to cross the 70% consensus threshold in round 1. These latter 3 were included in round 2, as a result of the majority verdict of HVs at the second meeting. The subsequent voting surpassed the 70% threshold for these three, although 'review of the range of options' and 'revisiting confidentiality' did not.

The majority of HVs felt that the agreed items (6 out of the 11) should be included in a first visit (of the HV intervention for mothers with MHPs). The six items were 'review of the reason for the package of care; checking for specific worries/concerns about illness, circumstances or the intervention; clarification of client understanding and expectations; tentative specification of what the package of care might include; planning for recovery; and agreeing format/contract for each session. Most of the delegates thought it was feasible to include these elements in the first visit of the intervention and they would be acceptable to mothers, but less than half of the HVs attending the meeting thought that it was 'probable' that these items would be included.

Owing to technical difficulties with the software, the voting for this question was not available from round 1 (Fig 8.13).

FIG 8.13 - PERCEPTIONS OF RELEVANCE OF CONTENT OF HV FIRST VISIT
(Total no. of HVs round 2 = 27)



QUESTION 12

WITH REGARD TO WHAT SHOULD BE INCLUDED IN THE FIRST VISIT . . .

A. I think HVs should include the elements referred to in the previous slide in a first visit

B. I think it is feasible for HVs to do this.

C. I think it is probable that HVs would do this.

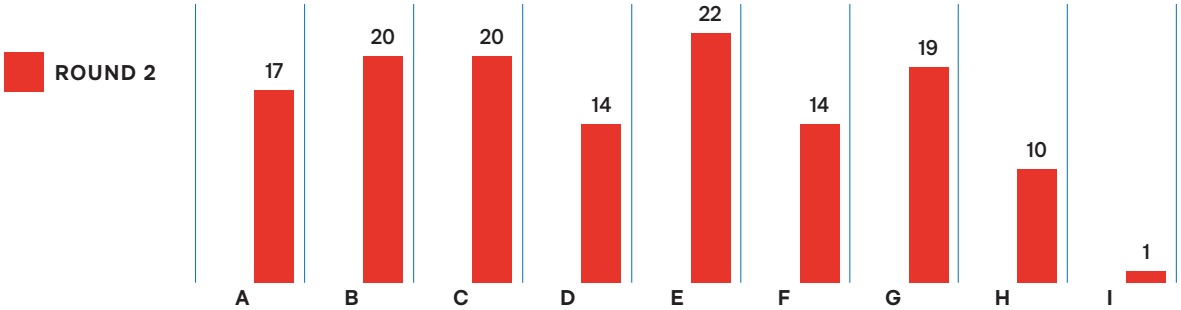
D. I think this would be acceptable to mothers.

8.4.1.10. QUESTION: WHICH OF THESE ELEMENTS DO YOU THINK SHOULD BE INCLUDED IN AN INTERVENTION FRAMEWORK FOR HVS?

HVs were asked to vote on the elements that they thought should be included in The HV intervention. Results are only available for round 2 as there was insufficient time in the first meeting.
The findings from the literature reviews and the survey were shared with the Delphi delegates and used to inform the questions about the preferred content of HV perinatal mental health interventions. Potential content was presented to the delegates in 2 batches of 9 questions (Figs 8.14 & 8.15).

FIG 8.14 - ELEMENTS TO BE INCLUDE IN HV INTERVENTION FRAMEWORK (PART 1)

(Total no. of HVs in round 2 = 27)



QUESTION 13

WHICH OF THESE ELEMENTS DO YOU THINK SHOULD BE INCLUDE IN AN INTERVENTIONS FRAMEWORK FOR HVS?

A. Behavioural activation.

B Modifying unhelpful behavior

C. Structured problem-solving.

D. Cognitive re-structuring.

E. Stress management.

F. Rethinking childhood experiences.

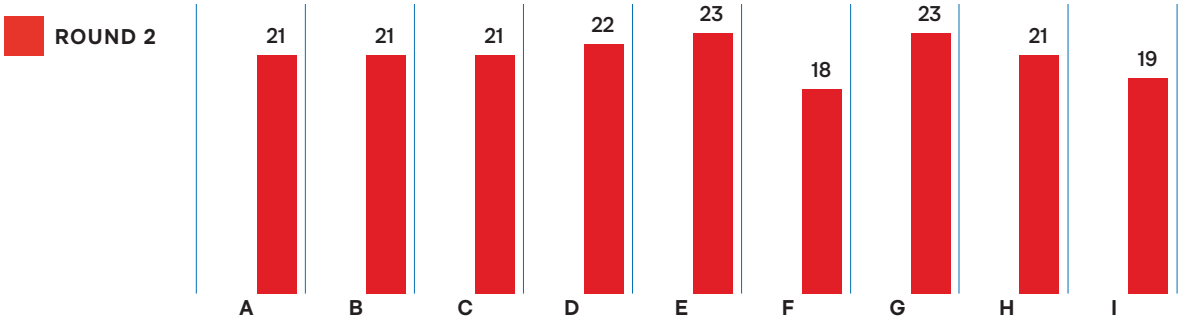
G. Fostering social engagement.

H. Expressive art making

I. Not sure

FIG 8.15 - ELEMENTS TO BE INCLUDE IN HV INTERVENTION FRAMEWORK (PART 2)

(Total no. of HVs in round 2 = 27)



QUESTION 14

WHICH OF THESE ELEMENTS DO YOU THINK SHOULD BE INCLUDED IN AN INTERVENTION FRAMEWORK FOR HVS?

A. Lifestyle – alcohol, smoking, drugs

B. Nutrition

C. Relaxation

D. Sleep

E. Exercise

F. Sunshine

G. Relationships

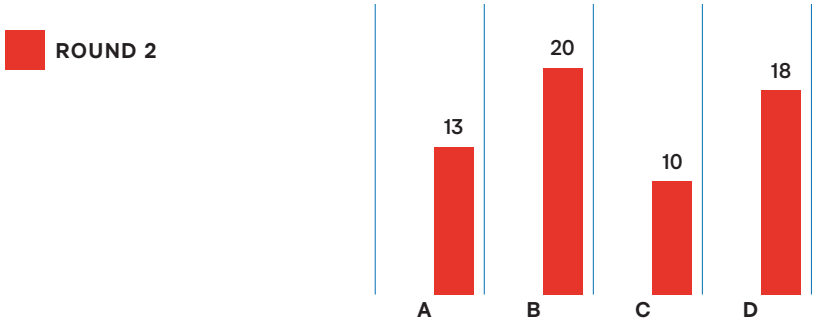
H. Social support

I. Biological considerations

The elements that failed to reach consensus were behavioural activation, cognitive restructuring, rethinking childhood experiences, expressive art making and sunshine.

Delphi delegates were also asked to vote on the likelihood that it would be feasible to incorporate CBT and lifestyle elements into the perinatal mental health package of care, and whether these elements would be acceptable to mothers. Less than half of the voters thought that CBT techniques should be included in a HV intervention and less than a quarter thought that lifestyle elements should be included. Over 70% thought that it would be feasible to incorporate lifestyle elements, it was probable that HVs would do so and that they would be acceptable to mothers. It is difficult to reconcile the finding from question 14 indicating that the majority of Delphi delegates thought that all the lifestyle elements in this question should be included with the finding that lifestyle elements in general, did not receive the support of the majority of the delegates (Fig 8.16 & Fig 8.17).

FIG 8.16 - LIKELIHOOD THAT HVS WILL INCLUDE CBT TECHNIQUES IN THE INTERVENTION
(Total no. of HVs in round 2 = 27)



QUESTION 15

WOULD IT BE APPROPRIATE TO INCLUDE CBT TECHNIQUES IN AN INTERVENTION FRAMEWORK FOR HVS . . .

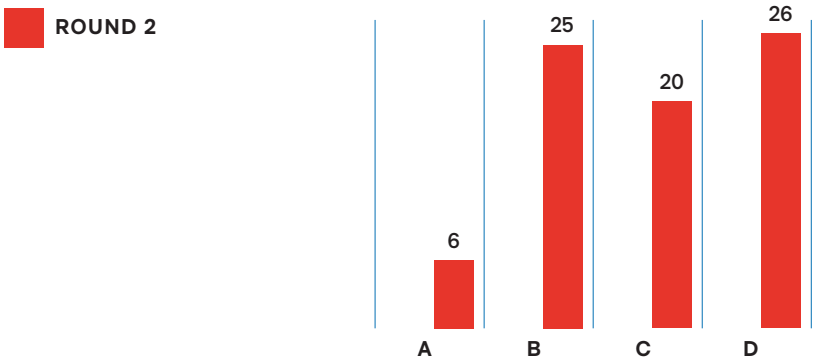
A. I think CBT techniques should be included in an intervention framework led by HVs.

B. I think it is feasible for HVs to use CBT techniques in the support they provide to mothers with MHPs.

C. I think it is probable that HVs will use CBT techniques to support mothers with MHPs.

D. I think it would be acceptable to mothers if HVs did this.

FIG 8.17 - LIKELIHOOD THAT HVS WILL INCLUDE LIFESTYLE ELEMENTS IN THE INTERVENTION
(Total no. of HVs in round 2 = 27)



QUESTION 16

WOULD IT BE APPROPRIATE TO INCLUDE LIFESTYLE ELEMENTS IN AN INTERVENTION FRAMEWORK FOR HVS . . .

A. I think lifestyle elements should be included in an intervention framework led by HVs.

B. I think it is feasible for HVs to include lifestyle elements in their intervention framework.

C. I think it is probable that HVs will include these elements in the support they provide to mothers with MHPs.

D. I think it would be acceptable to mothers if HVs did this.

8.4.2. HV guide for practice

The data from the Delphi Approach (content of notebooks, vote counts, researcher's diary notes), augmented by insights gained from the previous stages of research, was used to inform the content of a draft assessment and intervention framework manifest in the form of a guide for practice, based on a schedule of six scripted visits. Each Delphi delegate was given a copy of the guide at meeting 5. The guide included chapters on psychosocial assessment, psychoeducation, assessment and support. Each support visit included four suggested components: reflective listening; helpful activities; self-care; and a happiness task. All suggested activities could be offered at any time depending on the needs, preferences, goals and circumstances of the mother. A summary version of the guide is included in Chapter 9.

The delegates then took the guide back to their workplace (for 2 months) to ascertain from their colleagues and student HVs whether this would provide a useful blueprint for practice. At meeting 6, the Delphi delegates (n=25) provided feedback, including written comments, regarding the perceived utility of the framework (table 8.5). No negative comments were made.

TABLE 8.5. INDICATIVE COMMENTS FROM HVS ABOUT THE DRAFT INTERVENTION FRAMEWORK

Extremely comprehensive and provides a clear understanding of the role of a health visitor.
I believe the framework would be a useful tool for all health visitors in supporting mums with mental health conditions.
Provides useful suggestions to start challenging discussions – helpful for the inexperienced health visitor.
Excellent resource for both newly qualified and experienced HV. Clear, easy to follow. Gives good direction with regards LVs.
Booklet with happiness task and some information about sleep/nutrition and light. Very helpful to back up what we are saying.
The idea of a framework is really useful to help HVs feel more confident. HVs feel much more 'helpful', 'satisfied', good about their work when they are clear about having 'something' to offer. HVs need to understand that the 'connection' at any visit is often what helps and they need guidance in how to 'raise' that with a client in a way that does not create fear about dependency i.e. Talk about the importance of connection – friends/family/local shop worker – understand why it helps them to feel better about themselves.
Shared pack with colleagues with varying HV experience – pack seen as very useful, come good discussion ideas. Most HVs felt visits weren't structured and this is where the pack is very helpful.
Keep the basic structure of each visit very clear. Subjects and information can be interchangeable dependent on experience. Do have a clear structure for newly qualified students.
Will need to identify experienced HVs vs newly qualified given the useful discussion today re session layout . Or perhaps a rationale as to why the sessions are set out in this sequence.
Brilliant resource for staff to support and acknowledge and further develop skills and confidence with LVs. Much appreciated. Thank you very much.
Champions very keen to drive the framework forward – like the structure, felt safe and contained. Gives opportunity to explore areas further. Nutrition section very powerful – definite 'light bulb' moment for mother. She felt positive following the session, feeling she had something very practical to try. From my view point has informed me of new research out there, I absolutely feel upskilled after reading the framework. Practice teachers felt this would really benefit all HVs new and old.
Shared in Solihull group supervision. Staff were excited by it, found it to be a very useful tool.
Experienced CPT commented that she would find it very useful to use with student HV. Also commented that these were questions she hadn't thought of asking but was useful to include. CPT felt that there was a lot of learning for HV as a very experienced HV. Very much liked the idea of formatting the listening visits and providing some structure.
Feedback has been limited. It is of interest to HVs who want it but capacity always got in the way – it needs to be a given/must do but how can we get buy-in? 'Leadership support' similar to UNICEF BFI new revised standards could be facilitative to get 'buy in' as an example as it impacted on ownership for BFI input.
Really like it! Excellent resource for newly qualified/students and experienced HVs. Also excellent evidence of what we do and why we do it! Best of Luck.
Million dollar question – what do we call it – health visitor emotional well-being support/plan/health visitor maternal mental health support/health visitor brief therapeutic intervention.

8.5. Discussion

The Delphi approach has been used in this research as a structured communication process to facilitate collaborative learning and generate collective ownership of the fundamental elements of HV perinatal mental health practice. Consensus was reached for the majority of the items presented to the group, although this was sometimes only apparent after the second vote. This might be a consequence of the opportunity to reflect on the information presented and re-consider its relevance in the 2-3 months between meetings, or it could represent conformity to the norm or compliance with perceived expectations of the 'correct' response. This also reflects the purpose of the Delphi Approach which is to allow Delphi panellists to re-evaluate their opinions in the context of how other panellists perceive the item being scrutinised. Agreement was reached on the foundational traits and actions required by HVs; the timing of a comprehensive assessment of mental health; the importance of psychoeducation; the timing and process of assessment; the recommended number of visits in a HV intervention; the content of the first visit and the elements that could be included in the intervention that covered the rest of the visits that could be offered.

HVs were invited to vote on not only the elements that should be included in a HV intervention but also how likely it was that these elements would actually be included, whether it was feasible for HVs to include them, and whether HVs thought the elements would be acceptable to mothers. This yielded some interesting responses but these were sometimes difficult to interpret given the multiple elements in many of the preceding questions on which the answers were based. This meant that HVs may have suggested that a particular action was not feasible or probable when their answer related to only one part of the question.

Although I believe that exploring feasibility, probability and acceptability was a useful line of inquiry, the way the questions were designed may have compromised the validity of the answers. For many of the items, dissonance was apparent between the elements that the Delphi delegates agreed that HVs should do and the feasibility or probability of their implementation. Perceptions of probability did improve between rounds 1 and 2. It may be that there are contextual factors limiting the capacity of HVs to enact what they think should be done. Change takes effort. In the current climate of system re-organisation, staff shortages and unmanageable workloads it would be much easier to carry on doing what has always been done or defending the avoidance of change by arguing that it is not possible to deliver optimal care in all areas of professional responsibility.

My reflection after one of the meetings was that interest in new possibilities might inspire a change of practice but conversely may not necessarily equate to a change in practice. I did sense the frustration amongst the HVs about not being able to do what they thought was appropriate. Commitment to conducting a psychosocial assessment illustrates this point. Over 70% of the HVs voted that HVs should conduct a psychosocial assessment, that it was feasible for HVs to do, and acceptable to mothers but less than 70% thought that it was 'probable' that HVs would be able to do so. Issues around assessment were also reflected in the diverse range of responses to the question about the process of routine enquiries about emotional wellbeing, with the 70% consensus not being reached for any of the suggested options. Whilst there was agreement that a comprehensive mental health assessment should be offered at the antenatal contact, 6 weeks postnatally and 6-12 months postnatally, and HVs thought that it was feasible to do, and likely to be acceptable to mothers, the 70% threshold was not breached for the probability that HVs would be able to achieve this.

The traits that HVs agreed were essential in their interactions with distressed mothers were demonstrating warmth and acceptance; employing a non-judgemental approach; showing interests and empathy; creating a relationship based on trust; preserving the client's dignity, autonomy and self-respect; maintaining confidentiality; showing compassion; communicating a willingness to help; and tolerating uncertainty and ambiguity. The trait that failed to reach consensus on both occasions was 'maintaining humour, humility and curiosity'. This result might have arisen because HVs disagreed with one or two components of the trio of suggested characteristics.

HVs agreed that they provide anticipatory information about the sorts of MHPs that mothers might experience, the symptoms to look out for and who can help at the antenatal visit, the new birth visit and at the 6-8 week assessment. However, consensus was only reached after the second vote. Information provided prior to offering a comprehensive mental health assessment included HV knowledge and skills about maternal MHPs; prevalence and range of MHPs; timing and nature of assessment and what will happen next; the range of treatment options available; and allaying fears about losing custody of their baby. Only 2 of these items reached the threshold after the first vote – these were the prevalence of MHPs and the range of treatment options available. It may be that voting on an issue brings it into focus and prompts a personal review of professional practice.

Nearly half of the items proposed as 'content of the first visit' did not cross the 70% consensus threshold in round 1. Only 6 of the 11 proposed items remained after the 2 rounds (review of the reason for the package of care; checking for specific worries/concerns about illness, circumstances or the intervention; clarification of client understanding and expectations; tentative specification of what the package of care might include; planning for recovery; and agreeing format/contract for each session). Most of the delegates thought it was feasible to include these elements in the first visit of the intervention and they would be acceptable to mothers, but less than half of the HVs attending the meeting thought that it was 'probable' that these items would be included.

The 2 items excluded after the first round 'checking client preference for type of interaction' and 'discussing beginnings and endings' have been identified by mothers and HVs as important aspects of the therapeutic encounter. It is not clear why these items were rejected. Less than half of the delegates said they thought that HVs would 'probably do' what was suggested as 'content of the first visit.' Prior to voting, delegates were appraised of the research suggesting that many depressed clients disengage with therapy before, or immediately after, the first session and the benefits of anticipatory preparation for an intervention. It is encouraging that the majority of respondents would advise mothers that they can talk to HVs about both their physical health and emotional wellbeing, as evidence from research suggests that mothers are not always aware of the skillset of HVs, especially with regard to their knowledge about MHPs **(SLADE ET AL, 2010)**. In a recent survey, only 18% of parents would talk to a HV about their feelings so it is important that HVs pro-actively inform parents of their remit **(IPSOS MORI/THE ROYAL FOUNDATION, 2020)**.This is an issue that needs to be addressed in the future.

With regard to the number of visits that should be included in a package of care, the 70% threshold was not breached for any of the options although the majority of HVs opted for some combination of 6 or 8 visits with the preferred option appearing to be 2 + 6 visits. This implies that 2 visits might be needed to undertake further assessment of the range, severity and impact of symptoms and explore the most appropriate course of action for the mother and, then, if there was mutual agreement that a further 4 visits from the HV might be helpful, these would be offered.

The fact that at least 70% of the HVs agreed that the majority of the suggested items that should be included in a HV intervention implies that HVs acknowledge the value of a multicomponent intervention. The 'Broaden-and-Build Theory of Emotions' **(FREDERICKSON ET AL, 2008)** and 'Attention Restoration Theory' **(KAPLAN & BERGMAN, 2010)** were discussed with respect to the benefits of positive psychology interventions and immersive experiences in nature but these options were not included in the voting process.

The synthesis of evidence of the views of HVs (Chapter 6) presented in this thesis indicate that CBT techniques have frequently been mentioned as a useful adjunct to enhance the effectiveness of HV perinatal mental health interventions. The 70% consensus threshold was not breached for the CBT techniques of behavioural activation or cognitive restructuring and less than half of the delegates thought that HVs should use these CBT techniques in a perinatal mental health intervention. Explanations were given regarding the definition of these interventions so it is unlikely that the reason for their non-inclusion was a misunderstanding of their purpose. It was not possible to seek the views of the expert group on all the possible strategies and techniques that emerged from the preceding phases of the research that could have been offered for consideration by the expert group.

It was challenging to integrate the learning from all the stages of the research into a guide for practice whilst remaining mindful of the need to ensure that the HVs who had participated in any stage of the research would feel it was worth the effort of participating, that their views had been listened to, and their thoughts about what was needed would be incorporated into the end product. I was very much aware of the 'art and science of interpretation' in that I attempted to capture not only the facts as they were written and perceived but also the essence of what was needed from what had been said and left unsaid.

A message that kept re-presenting itself, in different forms, seemed to me to be the anxiety expressed by HVs about how to talk to mothers about sensitive issues or difficult topics, or how to respond when mothers share unsettling feelings, intrusive thoughts or a sense of detachment from their baby. On many levels, HVs seemed to be saying that without adequate training, they were starting from a point of 'not knowing' that exacerbated a sense of their own incompetence, that in itself was unsettling.

The production of a guide for practice needed to include all these elements and needed to be written in such a way that HVs struggling with 'not knowing' where to start or what to say would have an idea of how to approach talking about mental health problems, exploring vulnerability and resilience, assessing maternal mental state (beyond the limits of conventional assessment tools) and offering a specific intervention with clear boundaries and expectations that would help to improve maternal mental health, as well as protect the emotional wellbeing of the HV.

The presentation of the intervention as a series of scripted visits met with approval from the expert HVs and was considered a useful starting point for discussions about how to practice the art of healing conversations **(BELL, 2016; ELKINS, 2016)** and introduce a range of therapeutic and salutogenic strategies of proven effectiveness and acceptability to mothers and HVs. The intention is not for any HV to follow the script: it has been devised as a starting point for discussion with a knowledgeable other. Many HVs over the course of this programme of research have commented that as they have had very little training, and have never witnessed a LV, that they are sometimes at a loss to know what to say or how to proceed. Modelling first-person behaviours within a person-centred, recovery -oriented model of care is an

effective learning strategy that increases professional confidence and reduces stigma through improved provider-recipient interactions (KNAAK ET AL, 2017). The guide gives one version of how to provide anticipatory information about MHPs; conduct a psychosocial assessment and assessment of current mental state and offer a range of evidence-based interventions during the course of 6 weekly visits.

8.6. Strengths and Limitations

Anonymity is described as one of the cardinal features of the Delphi technique. Keeney et al (2011) have said that it is not required in a modified Delphi approach as the benefits of nurturing a relationship with delegates include improved motivation and lower rates of attrition. I think the HV experts enjoyed the opportunity presented by the meetings to reflect on how they approached LVs. The time required to travel to the venue (often 1- 2 hours drive) and to attend for 2 hours could have been prohibitive, but good attendance confirmed reported perceptions of the benefits of the interactive dialogue and illustrated the commitment of the delegates to participate in this collaborative venture.

There are advantages and disadvantages to face-to-face meetings. The advantages include resolving uncertainties about definitions, acknowledging mixed views, and sharing evidence and ideas. A disadvantage, in this case, is that a large proportion of the content of the discussion at each meeting was not captured. Over the course of 6 x 2 hour meetings, a larger amount of information was shared and discussed than is represented by the recorded feedback or the reflective diary kept by CL after each session. Smith (1991 P.201, CITED IN MOULES, 2002) talks about hermeneutics as 'the storied nature of human experience' and that 'good hermeneutical research shows an ability to read those stories from inside out and outside in.' Capturing the sense of positivity and collective endeavour is difficult to put into words and is not adequately reflected in the rather sterile results of the voting.

The unifying characteristic of the Delphi delegates was their expertise in perinatal and infant mental health. Different routes were pursued to acquire specialist knowledge and experience. By their continuing attendance and contributions to discussions the delegates demonstrated their enthusiasm for sharing their wisdom, delivering optimal, evidence-based care and an openness to the exploration of new possibilities. However, it may have been difficult for some delegates to reconcile strongly held beliefs or knowledge of workplace demands and organizational priorities with the proposals for improving practice that would inevitably demand time and resources. The views of this relatively small, highly motivated group of expert HVs may not reflect the views of the larger HV workforce.

It was difficult to know how best to include and present all the salient information acquired from the previous phases of research and achieve a balance in delivery between providing information, stimulating discussion and securing delegate feedback, in the time available. The information (powerpoint slides) presented during the meeting was shared with the HVs following their attendance. This was appreciated and may have contributed to their sense of involvement and engagement with the end product. Some delegates had to leave before the specified end time. Due to constraints of time, some voting did not take place.

The use of the voting pads required questions to be formulated in such a way to generate specific responses but risked oversimplifying the complexities of maternal experiences of MHPs. It is possible that the focus on easily definable elements detracted from the importance of the humanistic factors that determine outcomes but are difficult to measure. Discussion around the challenges of promoting positive mother-infant relationships revealed an understandable reticence to explore how a mother feels about her baby and her role as a mother, knowing that a primary maternal concern is that exposing how bad things really are might culminate in the baby being taken into care.

The final result of this Delphi approach may not provide the foundation for consistent, standardized, evidence-based practice because of the focus on easily quantifiable measures of assessment and process. Insufficient attention was given during the Delphi meetings to potential outcome measures that might provide the best indication of progress towards recovery for mothers, HVs, managers and commissioners. Items that reached consensus and those that didn't have been included in the guide for practice as personal communications from Delphi delegates suggest that all HVs should be provided with the evidence that underpins controversial issues so that they can make up their own minds about the components that they include and the format of the support that they offer. The challenge here lies in the ability to combine certainty about the purpose of the intervention and the essential elements that must be included and the flexibility that must be possible in order to provide responsive care.

Guzys et al (2015) state that awareness raising and the process of collaborative consultation using a Delphi approach are probably more important than the end result. Entries in my reflective diary suggest that the expert HVs appreciated the research evidence that was shared and the opportunity to discuss the implications for health visiting practice. However, the act of voting, with the associated technical difficulties, was more of an incidental extra and only seemed to provide superficial outcomes that were subject to review and change, or re-inclusion, in the second round, with the results ultimately discounted (by the HVs) as exclusive indicators of what should be included in a guide for practice. Although my sense is that, as a Delphi study, the results were inconclusive and the process of voting was less than satisfactory, something happened in the process of engagement that was productive and beneficial. I don't think any of the HVs thought that attendance at the meetings was not an appropriate use of their time and agreed that the prototype of the guide for practice that was produced reflected the work that we had done together and captured the elements that they thought should be included. I don't know how often HVs have the luxury of time and opportunity to explore and reflect on a specific aspect of their practice, but I think it would be beneficial if more collaborative opportunities were provided, as my sense is that both I, and the HVs participating in this consensus exercise, learnt as much from each other as from the evidence that was shared. Shared ownership of the process to explore the essential elements and agree the final content will hopefully increase the chances of further development, dissemination, implementation and sustainability of the re-designed HV intervention.

Data gathering involving the use of technology is subject to technical difficulties that are not always immediately apparent. Although, with Turning Point technologies voting system, a bar chart is displayed after voting to indicate the number of votes cast and re-voting can be instigated if necessary, it is not possible to check the information that is being stored. Responses to questions in both rounds are not always available. It may have been beneficial to engage in further rounds of voting. Practice in using the technology and piloting both the format and the method would probably have helped to identify and manage some of these issues. Combining e-delphi studies with consensus workshops may be a more successful method for collating the views of experts **(O'CATHAIN ET AL. 2019)**. Further opportunities to

combine digital solutions with practical wisdom need to be explored. It may be advantageous to use software programmes that have been developed to streamline the Delphi process, such as Mesydel, Expertlens, Delphi2 and Delphi Blue **(PARKS ET AL, 2018).**

8.7 Conclusions

This chapter describes the process and outcomes of a real-time, modified, technological Delphi approach set up to generate consensus about the core components and key clinical activities that could be included in a HV perinatal mental health intervention.

The Delphi Approach that was used appeared to be appreciated by the participants but was limited in its ability to deliver on the intended outcomes. A tentative consensus was reached about the characteristics of HVs that contribute to the establishment of trusting relationships, the sharing of anticipatory information about MHPs, the timing and process of assessment, the recommended number of visits that constituted a package of care and a range of components that could be included in a HV intervention.

A guide for practice was produced that incorporated the elements that 70% of the HVs participating in the Delphi study thought should be included. The items that were voted on did not adequately represent the breadth and depth of discussion that accompanied the presentation of the research evidence that provided the rationale for the items that were subject to the voting process. The content of the guide that was produced at the end of the Delphi process is augmented by the knowledge gained from all the previous stages of the research. It is a composite reflection of the range and impact of maternal MHPs (Chapter 3), the commonly occurring core components of effective interventions (Chapter 4) , the theoretical explanations of causal mechanisms of illness and mechanisms of action of interventions (Chapter 5), the needs of providers and recipient (Chapter 6) and the views and experiences of practising HVs (Chapter 7). The guide was shared with the expert HVs, who participated in the Delphi Approach. These HVs were invited to share the guide with their colleagues and provide some feedback regarding whether they thought it was what they were expecting, in the sense that it reflected the work that we had done together, and whether it would be a useful 'guide for practice.' The guide is a prototype and requires further examination and testing in practice, but the early signs that it is acceptable and useful to HVs, are encouraging.

8.8. Chapter summary

The findings from the Delphi approach represent the final phase of an emergent, mixed methods design whereby the findings from the survey and the literature reviews provide the basis of the content presented during the Delphi approach and provide the foundation for the development of a guide that can be used to inform the support that HVs provide to mothers with MHPs. The guide represents a culmination of my interpretation of all that I have read and learnt during all the stages of the research. Although it establishes some fundamental elements of effective interventions, it is not intended to be static or overly prescriptive. Talking with HVs in this last stage of the research process has made me more aware of the many influences that determine our thoughts and actions and the multiple ways in which the same words or actions can be interpreted.

Generating understanding inevitably arises from the to-and-fro interplay between what we believe we already know and what there is to know that might lead us to a new horizon. I am also struck by the circular nature of discovery, encapsulated in Gadamer's description of the hermeneutic circle. Many of the elements that are included in the guide for practice are construed by some HVs as basic common sense and just a re-iteration of what they already know or do. For example, a reminder of lifestyle factors as core elements that impact on mental health. Evidence continues to accumulate that re-visiting, re-considering, re-emphasising these elements can have a beneficial impact on mental as well as physical health. Gadamer refers to being open to possibilities but also to call forth the ordinary, to 'unconceal' that which has been concealed, to re-present the particular and bring it to presence (MOULES, 2002). This reminds me of a presentation at a conference by a mother with lived experience of MHPs who described the elements of the support provided by her HV that she found most helpful. Many of the elements that she described were those that are included in the guide for practice that I have spent 5 years researching. I could have just gone to the conference! A summary of the prototype guide for practice is included in the next chapter.

Chapter 9. Intervention design

9.1. Introduction

The final stage of the enriched development phase of the MRC guidance for developing and evaluating complex intervention is intervention design **(BLEIJENBERG ET AL, 2018)**. The output is a full prototype of the intervention. This chapter includes extracts from the 62 page 'guide for practice' that was produced as the result of integrating all the previous stages of the research and consulting with a group of expert HVs about what should be included in this first draft.

This chapter will include a summary of the contents included in the guide and an extract from three of the sections to provide an indication of the structure and style of the guide (shown in purple text). The relative merits of each section will be discussed prior to an exploration of the strengths and limitations of the guide and consideration of what needs to happen next to test and refine the guide and explore its transferability to universal HV perinatal mental health practice.

9.2. Emotional Wellbeing Visits

The intervention is being re-named 'Emotional Wellbeing Visits.' The intervention is called 'Emotional Wellbeing Visits' to emphasise that the role of the health visitor is not the same as the role of a specialist in mental health. The 'Five Year Forward View,' published in 2014, stated that 'The future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health' **(NHS ENGLAND, 2014B)**. It is therefore very appropriate that the EWVs intervention capitalizes on the public health remit of health visitors, by focusing on the promotion of emotional well-being, and the prevention, early detection, and prompt and appropriate treatment of mental ill-health.

Furthermore, emotional wellbeing fits with the recommendations in the NICE guideline for antenatal and postnatal mental health **(NICE 2014A)**. The NICE quality standard on antenatal and postnatal mental health highlights that women should be asked about their emotional wellbeing at each routine antenatal and postnatal contact. The concept of emotional well-being fits with what mothers want. In a meta-synthesis of 36 studies from 15 countries, mothers wanted to feel that they were coping with the demands of motherhood, adapting to changed intimate and family relationships and (re)gaining health and well-being for both their baby and themselves **(FINLAYSON ET AL, 2020)**.

Emotional wellbeing fits with the Boots 'Emotional Wellbeing Plan' that some health visitors and midwives are using in the antenatal and postnatal period to raise awareness about PIMH, to help parents to recognise symptoms of mental ill-health, and to provide information about who they can turn to for support. In some areas, the 'Emotional Wellbeing Plan' has been incorporated into the red book so parents will be familiar with this language. The 'Emotional Wellbeing Plan' is also available on the Tommy's website and has been approved by NICE.

The intervention is called 'Emotional Wellbeing Visits' because research suggests that both health visitors and mothers find the term 'listening visits' is either not a fair representation of what health visitors do or does not give mothers a clear indication of what to expect from the intervention that the health visitor is offering. 'Listening' is still very important but some mothers find the expectation that they have to talk in order to be 'listened to' quite intimidating. Some health visitors are not quite sure what is expected of them in 'Listening Visits'. Mothers can be worried about sharing the thoughts and feelings that are troubling them or may just find it difficult to talk because of their low mood. Qualitative research has suggested that mothers do want to be listened to, but they also want some suggestions about simple,

easy-to-do activities that will help them to feel better. Doing something that other mothers have tried, or that evidence suggests is helpful, helps mothers to feel that they are not the only mothers feeling the way that they do and that if other mothers have recovered, so can they.

9.3. Content of the guide

The guide includes an overview that describes the process of development of the guide and the research process that led to the identification of core components and key clinical activities that could be included in an intervention delivered by non-mental health specialists to community-based mothers with MHPs. In the overview, the core components are grouped under the headings of context, therapeutic alliance, psychoeducation, integrated assessment, nurturing relationships, and therapeutic interventions, but subsequently the different elements are integrated into different sections of the guide.

Following the overview there are 4 further sections of the guide: psychosocial assessment, psychoeducation, assessment and providing support. Three of these sections will be used in this chapter to provide an indication of the format and content of the guide. Each section is in the form of annotated script. The notes refer to the evidence underpinning the question or element, or contain additional facts of interest, or alternative ways of conducting assessments if the mother does not want to engage with the conventional assessment process. An appendix contains a summary of the content of each section designed to serve as an aide memoire for HVs. A reference section provides details of the literature cited throughout the guide. Excerpts from the overview and the sections on psychosocial assessment and providing support are included as illustrative examples of the guide. It is anticipated that the immediate response of some HVs when they read the guide is that they wouldn't use the same words, phrases or terms in their contacts with mothers. That is the intention of the guide. The guide is meant to provide a starting point for reflection and discussion. Each of the following three sections (9.4, 9.5, amd 9.6) are exact replications of the sections in the guide.

9.3.1. The overview

A summary of essential pre-requisites for practice and the key clinical activities required to assess and support mothers with MHPs are included in the overview.

Essential prerequisites to enable HVs to deliver effective, acceptable, evidence-informed perinatal mental health care

Access updated and evidence-based training delivered by competent facilitators.
Receive practice-based 'coaching' in intervention implementation.
Participate in peer support and supervision.
Be aware of referral pathways, thresholds and networks of support.
Attend consultation sessions with relevant experts.
Engage mothers in reviewing the efficacy of the intervention.
Use outcome measures to monitor satisfaction and change.

Have systems in place to monitor and evaluate treatment adherence and practitioner competence.

Essential interactive qualities required by the HV

Establish, develop and maintain a supportive therapeutic alliance.
Demonstrate warmth and acceptance.
Employ a non-judgemental approach.
Create a relationship based on trust.
Show genuine interest and empathy.
Preserve client's dignity, autonomy and self-respect.
Offer positive encouragement and support.
Listen carefully and only ask appropriate questions.
Encourage expression of feeling/Reflect back content and feeling.
Be sensitive and responsive to verbal and non-verbal cues.
Encourage personal responsibility.
Communicate a willingness to help.
Show compassion.
Keep an open-mind.
Be flexible in thought and action.
Tolerate uncertainty and ambiguity.
Maintain a sense of humour, humility and curiosity.
Keep your own boundaries.
Recognise limits of professional competence and practice.
Be aware of own, beliefs, values and expectations (unconscious perceptions, assumptions, interpretations and bias).

Provide clear information about the role of the HV

Communicate professional role and responsibilities in relation to maternal mental health/make sure mother knows that you are concerned about the health and well-being of everybody in the family and that you have the skills and expertise to help with mental health problems.
Set clear parameters regarding confidentiality and safeguarding.

Provide information about common MHPs and sources of support

Provide information about maternal emotional well-being, common perinatal mental health problems/ why vulnerability to mental health problems is increased during pregnancy and after birth
Provide anticipatory guidance
normalize help-seeking for emotional difficulties.
explain formal and informal assessment processes
describe range and sources of support and ways to access help

Prepare to deliver EWV intervention

Enhance a sense of security and containment by providing a safe physical and psychological space to share personal experiences and reveal feelings, concerns and uncertainties about parenting.
Acknowledge that it takes time to establish a trusting relationship in which the mother feels able to share what is on her mind.
Suggest that just as it has taken time and a combination of circumstances to lead to current feelings of distress, it is likely that it will take time and a combination of activities/interventions/circumstances to feel better.
Use expectancy enhancement strategies to instil hope and optimism/communicate a normalizing recovery-focused message.
Explore explanatory models of motherhood and mental illness and maternal beliefs and preferences about what might work and preferred interactional style
Indicate that recovery is an ongoing process that begins with talking about the things that are affecting the way that you feel, your ability to cope, what you do, your relationships with others and the sense of who you are.
Clarify expectations of intervention including duration, frequency, content, expected outcomes and review/emphasise importance of negotiated therapeutic contract (consistency, predictability, routine).
Allay fears e.g. of social care involvement/baby being 'taken away'.
Emphasise importance of negotiated therapeutic contract) consistency, predictability, routine)
Provide a clear timeframe for each session so that the mother can choose when to share information within each session or across sessions to avoid discontinuation at inappropriate times/opportunity to assemble thoughts and decide when to share them/providing some sense of control.
Give due regard to appropriate endings to ensure that the mother is not left vulnerable, unacknowledged and unable to face the world.

Develop a shared understanding of what the mother is experiencing

Allow mother to describe how she is feeling in her own words and to share what is on her mind
Appreciate the uniqueness of the experience of maternal distress/the lived experience of health and illness is different for everyone.
Appreciate the uniqueness of the experience of maternal distress/the lived experience of health and illness is different for everyone
Accept that mothers may not express their distress in terms of diagnostic criteria and may be experiencing all sorts of other emotions/may just have a pervasive sense of feeling overwhelmed/not coping/not able to function/feeling lonely/struggling with relationships.
Keep in mind that there might be factors that influence the likelihood of the mother being able to share her thoughts and feelings (presence of others, cultural beliefs and practice).
Facilitate identification of sources of maternal and infant and family stress.
Facilitate maternal expression of concerns and expectations.
Acknowledge maternal ambivalence and uncertainty.
Elicit maternal personal narrative/childhood experiences/past and current relationships/journey into parenthood
Explore the meaning and impact of important experiences.
Enable consideration of strengths and resources as well as difficulties
Identify past ways of coping/including review of strategies that might not be helpful (alcohol, smoking, self-harm)
Explore capacities for change and growth/readiness to change/motivation.

Explore future focused possibilities (If you could change three things in your life what would they be?
Demonstrate a shared understanding of what the mother is experiencing and a plan for overcoming any difficulties identified.
Find out what the mother considers as evidence of improvement/feeling better (NB restoration of social function may be more important to mothers than reduction in symptoms).

Tailor the intervention to suit maternal needs, preferences and circumstances
Offer choice and support informed decision-making.
Exchange evidence and ideas.
Explore treatment options in an atmosphere of hope and optimism that leads women to believe that care will be effective and recovery is possible
Regularly review needs and risks.
Facilitate exploration of possible sources of social, emotional and practical support.
Consider the interplay between physical and mental health.
Support maternal self-care (nutrition, exercise, sleep, rest, sunshine, pleasurable activities).
Help mother to regain their self-management abilities.
Help to overcome the cognitive-behavioural factors maintaining their difficulties/facilitate collaborative problem-solving, behavioural activation and thought modification/stopping.
Maintain a holistic family-centred perspective that takes into account the well-being of all family members.
Enable exploration of the importance of family systems.
Observe and reflect on relationship dynamics and attributions.
Consider the needs of each parent, each child, and the relationships between them.
Nurture parent-infant relationships.
Provide opportunities to discuss thoughts and feelings about infant management and the transition to motherhood.
Explore strategies to consolidate change and cope with future difficulties.

9.3.2. Section on psychosocial assessment

9.3.2.1. Introduction to section on psychosocial assessment

It is not just about identifying the negatives, the purpose of psychosocial assessment is to gain an overview of the woman's life circumstances in order to develop a 'holistic, integrated, woman-centred approach to emotional health.' **(MILGROM AND GEMMILL, 2014)**. It is therefore important not to appear as though you are only looking for the challenges and difficulties.

However, there are aspects of vulnerability that contribute to maternal emotional well-being that it would be helpful to know about. Assessing maternal mental health is not as straightforward as just asking the relevant identification questions or using a validated assessment tool. Symptoms of anxiety and depression can mask a number of underlying and serious psychosocial comorbidities such as interpersonal violence, substance misuse or a history of adverse childhood experiences **(AUSTIN ET AL 2015)**.

Sensitive enquiry into past and current vulnerability factors is therefore required in order to ensure that all comorbidities are considered, safeguarding issues are identified and any recommended interventions are tailored to need. It is important to remember that stressful living conditions and life experiences can either individually or cumulatively predispose to maternal mental health problems. Bearing in mind the sensitive nature of some of these questions it is preferable to ask to see the mother on her own, if possible, in the first instance.

Before starting on any kind of assessment it is important to make sure that the mother understands what you are there for and the sorts of things/areas that you might be able to help with. Of course there is never only one way of doing anything and everybody has their own ways of communicating/sharing information. The idea behind providing a 'script' is not to follow it but to provide an opportunity for student health visitors to explore with their tutors and mentors what they think are the essential aspects that they need to include in their contacts with mothers and to reflect on their own personal style of communication.

It is probably also important to remember that a pregnant or new mother may be meeting a number of different health professionals and other practitioners in the perinatal period and, from her point of view, it may be difficult to know whose responsibility it is to do what, in whom she can confide, and what is going to happen to any information that she might share with any particular professional. It is therefore vital that mothers are aware of the specific skill set of health visitors and the extent of their technical competence and remit.

A great skill of health visitors is their capacity to cope with complexity and manage uncertainty as they never know what they are going to find at any contact. This may be particularly unsettling during training and the early years of health visiting practice. Whilst is OK to be honest about the limits of your experience it is also important to convey the impression that you have the knowledge and capacity to provide appropriate, sound, non-judgemental help and support when needed. Mothers are more likely to seek help if they perceive the health professional as knowledgeable, genuine and approachable **(DENNIS AND CHUNG-LEE 2006)**.

The purpose of this script is also to reduce the sense of 'not knowing'. Before embarking on any visit covering psychoeducation, psychosocial assessment or the mental health needs of the mother, the father, the baby and the relationships between them it might be helpful to look at the script to make sure you know what to do in response to aspects of vulnerability or need that might be disclosed during the course of your visit. Different services and referral pathways will exist in different areas. It might be useful to find out what services or help is provided by the voluntary sector and to have an idea of real or virtual sources of information and support for different types of need.

When researchers have interviewed women after they have received a 'listening visit' intervention from health visitors, several studies have shown that women did not understand the role of the health visitor: specifically they did not understand that the health visitor was there for the mother as well as the child. If they were aware that the health visitor was also there for the mother, they did not necessarily know that the health visitor was trained to help them with psychological difficulties/mental health issues **(MORRELL ET AL 2009, SHARP ET AL 2010)**.

A number of studies have suggested that mothers have not felt listened to, understood, or cared for by the health professionals responsible for looking after them. Some women have suggested that it does not feel as though they are part of a two-way conversation, the health professional often appears stressed and rushed and the way that questions are asked is formulaic and insincere **(HENSHAW ET AL 2011, COATES, AYRES, DE VISSER 2014, RUSSELL, 2017)**. Furthermore, some women have felt that there was a lack of knowledge amongst health professionals about the range of perinatal mental health conditions that women might experience and a preferential focus on depression, so that if the symptoms experienced did not fit with this category of illness there was no further discussion or offers of support tailored to

the woman's needs (LOGSDON ET AL 2012, RCOG 2017). A qualitative meta-synthesis of the health visitor's role in the identification and management of perinatal mental health problems indicated that it is not uncommon for health visitors to find it difficult to talk about sensitive issues especially if uncertainty exists as to how to respond to disclosure or local provision of appropriate services is inadequate to meet demand (NOONAN ET AL 2017). It is therefore important to remember that you might be feeling stressed, rushed and vulnerable yourself and whilst you may have several other visits still to do, the mother has set time aside for this one visit and it is important that you give the mother the impression that you are able to give her your full attention during the allocated time for the visit.

Wampold and Imel (2015) suggest that humans make a decision about whether another person is trustworthy or not based on the first 100 milliseconds of seeing their face, implying that patients make a very quick decision regarding whether they think they can trust their therapist. The importance of first impressions is further suggested by research that indicates that more patients terminate their therapy after the first session than at any other time. (CONNELL ET AL 2006). Moreover, uncertainty reduction theory (BERGERAND CALBRESE, 1975) asserts that prior to interacting with a stranger a person needs information about that person in order to reduce their uncertainty and foster their motivation to engage in a reciprocal relationship.

The psychosocial assessment might be automatically included at the contact where you undertake to complete the Family Health Needs Assessment and therefore there will be a significant overlap with the topics that you are exploring. There may also be some overlap with the antenatal and postnatal promotional interviews if these are being used in your organization. The important point to remember with these tools is that you still need to ensure that you have covered all the relevant issues (see appendix for antenatal checklist). If you have not completed a comprehensive psychosocial assessment during your first contacts with a mother then it is imperative that you cover these topics as part of the maternal mental health assessment process.

> **NOTE:** All the indented text relates to evidence underpinning the topics or questions and/or additional information that it might be useful for the health visitor to know. Generally speaking it is not information that should be shared with the mother but of course this remains at the discretion of individual health visitors and their knowledge of, and relationship with, the mother.

9.3.2.2 Proceeding with the psychosocial assessment

Each of the sessions involving contact with the mother has a series of headings followed by a series of questions or topics accompanied by notes providing supporting evidence, or interesting facts relevant to the identified topics. The detail of the content of the first few sections of psychosocial assessment is included to illustrate the format of the guide and to demonstrate how the 'script' is linked with the relevant evidence/facts. The headings for further sections are subsequently included to indicate the breadth of content included in the section on psychosocial assessment.

ROLE OF THE HEALTH VISITOR

I am not sure how much you already know about health visitors. Would it be helpful for me to tell you a little bit about my role? All health visitors are qualified nurses or midwives who have usually worked for a while as a nurse or a midwife before doing an extra year of training in specialist community public health nursing – basically - health visiting. The public health bit means that our role is about promoting health and preventing disease for the whole population (so we visit everybody) and we specialize in supporting families with children under 5. I work as part of a team which includes . . . Between us we offer a specified number of visits to all families from pregnancy until the child is two years old and then we can offer extra support to families who need it at any time from pregnancy until the child starts school.

CONFIDENTIALITY

We are employed by . . . We have links with other health professionals like midwives and GP's and Local Authority services like Children's Centres. Sometimes it is really helpful to share relevant health information with your GP or midwife so that you don't have to keep saying the same thing to lots of different people. Sometimes we need to collect information to share with the Public Health department of the Local Authority so that they know how many families with small children live in the area and what their needs are. Although we have links with other services, anything we talk about is confidential and I will not share any information with anyone else unless I have your permission to do so.

DUTY TO PROTECT CHILDREN AND VULNERABLE ADULTS

The only exception would be if I was concerned that anybody in the family was at risk of harm but even then, I would always talk to you first about my concerns (unless there is some kind of emergency). Just like anybody who works with families I have a duty to protect children and vulnerable adults but that is not my main role.

My job as a health visitor is to help families to keep as healthy as possible and to support parents in bringing up their children so that they are happy, healthy and safe and ready for school when the time comes. Every family in the country is offered a visit from a health visitor at certain times in the baby's life to provide an opportunity to assess the baby's development and talk about any issues or concerns parents may have. You can also contact me at any other time for advice or information if you want to.

HEALTH AND WELL-BEING OF ALL MEMBERS OF THE FAMILY (INCLUDING PSYCHOLOGICAL HEALTH)

I have a responsibility to help parents to think about all the things that might have an impact on the health and well-being of everyone in the family and to give them information about the services and types of support that are available that it might be useful to know about. The physical health and psychological well-being of parents is just as important to me as the health, growth, development and safety of children so you can talk to me about anything that might be affecting the health and well-being of anyone in your family.

I may not always be able to provide the support that you need but because I have contact with lots of other professionals and services we can work out together who might be the best person to help. I can then support you in getting the help that you need.

We offer all new mums an antenatal visit so that we can start to get to know each other and to talk about how the pregnancy is going and what it might be useful to think about before the baby arrives.

BECOMING A PARENT

Becoming a parent is a major life event. Many women have never been pregnant before and lots of parents have not had very much experience of looking after babies before they have one of their own. So, whilst you see the midwife or the doctor to monitor how you and the baby are doing, my job is to talk to you about some of the other things that it might be useful to think about now you that you are going to have a baby. Is that OK with you?

THOUGHTS ABOUT PREGNANCY

Is this your first baby?
How did you feel when you found out that you were pregnant? How are you feeling about it now?
Do you have a partner? Is it your partner's first baby?
What was your partner's reaction to the pregnancy?
Is he/she supportive/attending appointments with you/planning to be there at the birth?

> **NOTE:** Many studies have found an increased risk of developing antenatal depression or anxiety with unplanned or unwanted pregnancies. Data from 12,462 partnered mothers participating in the millennium cohort study indicated that 32.8% mothers had an unplanned pregnancy. Unplanned pregnancy was associated with increased risk of psychological distress postpartum especially amongst women who felt unhappy or ambivalent at the start **(BARTON ET AL 2017)**. A negative experience or outcome of a previous pregnancy may also affect maternal mental state.
>
> It must also be remembered that some conceptions might be the result of an abusive sexual encounter that the mother may or may not want to talk about. Mothers who have experienced any kind of recent or childhood maltreatment may re-experience the sense of feeling violated or out-of-control during the course of antenatal assessments or delivery (and may avoid appointments) or may feel disconnected or emotionally numb. Women who have experienced childhood maltreatment are 12 times more likely to experience PTSD during pregnancy. This is often co-morbid with depression **(SENG ET AL 2009)**.

EXPECTATIONS

How have you felt during the pregnancy?
Is it what you were expecting?
When did you last see the midwife? Is everything going OK?

> **NOTE:** High risk pregnancies (when the progression of the pregnancy, the well-being of the mother or the health and development of the developing baby are giving cause for concern) understandably may cause significant parental distress and exacerbate a maternal sense of feeling out of control and helplessness **(STAHL AND HUNDLEY 2003)**. Therefore it is important to provide an opportunity for the mother to talk about any concerns that she may have and to establish what additional support she may need and who will provide it. It is also good to know if the mother has been able to talk about the risks with her partner.

Do you feel that you have been given all the information that you need about what is happening to you and your baby during pregnancy?

> **NOTE:** This may be an appropriate opportunity to suggest sources of information that may be helpful e.g. The Baby Buddy app.

KEEPING WELL

Have you been given information about how to keep yourself as well as possible during the pregnancy? For example, has anyone talked to you about the importance of getting enough sleep, eating a healthy diet and taking regular exercise?

Your body is building a baby so it is important to make sure you eat enough of the right sorts of foods and not too much of the wrong sorts of foods. Then there are some foods that are best avoided altogether . . . has someone talked to you about what those foods are?

What you eat is not just important for your baby but it is also important for you so that both you and your baby are less likely to experience health problems as the pregnancy progresses. The trouble is that the more pregnant you become sometimes it becomes more difficult to eat the right things . . . you might not feel like eating because you feel uncomfortable or you just don't feel like preparing or cooking food.

> **NOTE:** Available data from nearly 7,000 families participating in the Avon longitudinal birth cohort (ALSPAC study) indicated a relationship between unhealthy diets and depressive symptoms during pregnancy **(BARKER ET AL 2013)**. A large longitudinal observational study involving over 20,000 Norwegian mothers and their children found that higher intakes of unhealthy foods during pregnancy was related to an increased risk of emotional and behavioural problems in the children between 1 and 5 years of age after allowing for the influence of confounding variables such as childhood diet although if the child also had an unhealthy diet the behavior problems were more pronounced **(JACKA ET AL 2013)**.

Do you find that you feel like eating/cooking/preparing food?

> **NOTE:** Healthy eating can be specified as a diet of nutrient-rich foods, with limited intake of salt, solid fats and added sugar. Healthy foods are those that are high in protein (e.g. fish, pulses), dietary fibre (e.g. pulses) and high in important nutrients such as folate, magnesium, potassium, and vitamins A, C and K (e.g. vegetables) **(BARKER ET AL 2013)**. The right kinds of fats are also important as these are particularly important for growing the foetal brain and nervous system. Although there are mixed results regarding the benefits of supplementing with Omega 3, it is nevertheless an important component of the antenatal diet.
>
> It is also the pattern of eating that sometimes compromises maternal and foetal health – for example, going without breakfast and compensating with cakes, doughnuts and sweets. More information about diet is available in the section on Self – Care. Or can be obtained from the First Steps Nutrition Trust which has a leaflet on 'Eating Well for a Healthy Pregnancy.' (www.firststepsnutrition.org)

Have you been given any information about antenatal classes/what to expect when you go into labour?

> **NOTE** It might be appropriate to share information about local provision at this point or recommended internet sites that your organization have agreed to endorse. e.g. www.tommys.org

Have you decided where you are going to have the baby?
Is there anything that you have been particularly concerned or worried about or anything that anyone has told you that you weren't quite sure what they meant?
Have you been able to talk to someone about anything that is on your mind?
Is there anything that you have found particularly helpful/unhelpful? Is there anything that I can help you with?

> **NOTE:** Fear of childbirth (tocophobia) appears to be increasing in incidence and can be present in both nulliparous and multiparous women. The global prevalence of tocophobia has been estimated at 14% **(O'CONNELL ET AL, 2017)**. Contributory factors include previous traumatic experiences (including sexual abuse and birth trauma); long duration of infertility; poor social and partner support; perceptions of unhelpful, unfriendly or unavailable midwifery staff; an anxious, depressive or compulsive personality; low self-efficacy (belief in ability to cope with the pain and process of childbirth) and decisional conflict (about birth choices) **(O'CONNELL ET AL 2017, TOOHILL ET AL 2014**). Asking women specifically about their expectations/fears can lead to improved childbirth confidence which may, in turn, culminate in better outcomes for the mother and the baby.

THOUGHTS ABOUT THE BABY

Can you imagine what your baby will be like?
Do you have an ultrasound scan picture? Have you heard your baby's heartbeat?
Do you know what sex the baby is?
Have you thought of a name for your baby?
Does the baby seem to be more active at certain times of day?
Have you noticed anything that the baby seems to respond to?
Do you and/or your partner like to talk/sing/play music to your baby or massage your abdomen/baby?

> **NOTE:** Shieh et al (2001) have concluded that maternal – foetal attachment consists of three critical attributes – the desire to know the baby (cognitive attachment); the pleasure associated with interacting with the baby (affective attachment) and the desire to protect the foetus (altruistic attachment). Positive maternal attributions about the foetus predict positive self-care during pregnancy and better neonatal outcomes **(MADAHI ET AL 2016)**. Mothers who feel close to their babies antenatally experience less postnatal depression **(GOECKE 2012)**.
>
> A study in Italy compared outcomes for mothers and babies of mothers who sang lullabies to their babies from 24 weeks of pregnancy with mothers who didn't sing to their babies. In the singing group the bond between the mother and baby was stronger after birth; the incidence of baby crying episodes was significantly lower in the month after birth; babies experienced less colic in the two months after birth and there was a reduction in overall night-time wakening. There also seemed to be a be a reduction in perceived maternal stress in the early postnatal period **(PERSICO ET AL, 2017)**.

EXPECTATIONS OF PARENTHOOD

Have you had much experience of looking after babies?
Have you thought about how you will find out what you need to know?
Have you thought about what it will be like to be a parent?
Have you and the baby's father/other parent talked about what it might be like to be parents?
What do you think he/she will be like as a father/co-parent?
How do you see your life changing after the baby arrives?

PARTNER AND FAMILY SUPPORT

Have you talked with your partner about the sort of help you might need and who is going to do what?
Is your partner generally helpful?
Do you share household tasks?
Can you talk with your partner about things that you are worried about?

> **NOTE:** One of the most frequently cited risk factors for perinatal distress (depression and anxiety) is an unsatisfactory relationship with the partner that may or may not include lack of support **(RØSAND ET AL 2011)**. Pregnant women who perceive their partners as supportive experience less postpartum distress **(TANNER STAPLETON ET AL 2012)**.

Do you live near your parents/in-laws? Are they supportive?
What do they think about the pregnancy?
Will they be around to help once the baby is born?

> **NOTE:** If parents are not alive, the prospect of becoming a parent can make a mother or father more aware of their absent parent and possibly profoundly sad that they are not around. The proximity of parents may not always be a good thing and therefore it is important not to make any assumptions. As a result of our own experience of being parented or as a result of the relationship that we have with one or other parent, we might resolve to give our children the same kinds of experiences that we had OR we might resolve to make sure that we do not parent our children in the same way that we were parented. Becoming a mother makes you think about how you were mothered and the relationship that you have/had with your mother and that might trigger all sorts of feelings including sadness, frustration, anger, resentment. Sensitive enquiry is therefore very important.

Who else in your family or in your circle of friends might be able to help?

> **NOTE:** This might be an opportunity to do a genogram and/or an ecogram.
> Social support is a multidimensional concept and includes information and advice, practical help and emotional support **(LEAHY-WARREN, MCCARTHY AND CORCORAN 2011)**. Perceived support contributes to psychological well-being even in the context of an unstable social network. It is especially important to identify sources of support available to single mothers **(REID AND TAYLOR, 2015)**.

OWN EXPERIENCE OF BEING PARENTED

Sometimes having a baby makes you think about your own childhood.
What memories do you have of your childhood? Happy? Sad? Good? Bad?
Unhappy memories can sometimes stay with you and make you more vulnerable to mental health problems whilst you are growing up or when you have a baby of your own. Sometimes it helps to talk about your experiences.

Do you have someone you can talk to about these things? Would you like to talk to me?
Of course, as I mentioned earlier, anything you say to me is completely confidential unless the things you share suggest that someone is at immediate risk of harm and then I would have to see what I can do to make sure that, whoever it is, is safe. Sometimes it just helps to talk. Whatever we talk about we can think together about what you want to do next.

> **NOTE:** It has been suggested that the strongest predictor of antenatal depression is the mother's experience of being maltreated as a child **(NICE 2014)**. The millennium cohort study also found that women who had experienced any period of being 'looked after' by the Local Authority prior to the age of 17 were more vulnerable to maternal depression **(BOTCHWAY, QUIGLEY, GRAY 2014)**.

PERSONAL HISTORY OF MENTAL HEALTH PROBLEMS

Sometimes, even though people learn to cope with mental health problems when they are teenagers, or adults, the symptoms can come back during pregnancy or after the baby is born. If that is the case, it is important to get the right kind of help as soon as possible.

Have you, or anyone you are close to, ever been worried about your mental health?
Did you get any kind of help?
If so, who did you see? When did you see them? For how long?
What treatment did you have? Was it helpful?

Additional topic headings in this section are as follows:

PAST OR CURRENT MEDICATION
PARTNER'S MENTAL HEALTH
FAMILY HISTORY OF MENTAL HEALTH PROBLEMS
STRESSFUL LIFE EVENTS
COPING STRATEGIES
SMOKING, DRUGS AND ALCOHOL
PROTECTION FROM HARM
WHO CAN HELP?
ADDITIONAL CONSIDERATIONS REGARDING PSYCHOSOCIAL ASSESSMENT TO TAKE INTO ACCOUNT AT THE NEW BIRTH VISIT

9.3.3. Section on providing support

HVs need to be convinced, and convincing. that the support they are offering to mothers with MHPs will culminate in improved family emotional wellbeing. HVs have to believe that what they are offering will be helpful. Mothers have to believe that investing their time and energy in contacts with the HV will make a difference to them. Offering a package of care, rather than a one-off contact, validates maternal experience of psychological distress and conveys a clear message that the HV has the time, skills and motivation to listen and help.

In the series of 6 visits that constitutes the recommended package of care, the first visit is an introductory visit and the last visit provides an opportunity for reviewing progress and deciding on next steps. Visits 2-5 all follow the same format. The priority of all visits is to enable the mother to express how she is feeling and talk about anything that she wants to talk about. A priority is also to ask the mother if she has any thoughts about what might help her to feel better. In the beginning, as trust is developed, the mother may not be ready to talk about the thoughts and feelings that are causing greatest concern. This is when the mother might appreciate some suggestions from the HV of easy-to-do strategies that will instil hope and optimism and help her to feel that recovery is possible.

Having a specified time and duration for the visit as well as a structured format for every visit help to provide a safe physical and psychological space for the mother so that she knows what to expect and can choose when to disclose worrying thoughts and distressing feelings. Although there are specified interventions for each visit, these are just selected from a range of evidence-based interventions that can be offered at any time in response to the symptoms, needs and preferences of the mother (table 9.1). The detailed guide includes specific instructions on what the HV needs to do to help the mother to enact the specified techniques/strategies.

For example, one of the two depression identification questions asked of every mother is whether they have lost interest or pleasure in things. This is a cardinal symptom of depression. A strategy that might help to begin to re-kindle maternal pleasure in enjoyable activities, is behavioural activation. This is the rationale for why behavioural activation is one of the techniques advocated in visit 2.

A clear beginning and end to each visit also enables the HV to ensure that the mother has time to bring herself back to the present, before the HV leaves, as there is always a risk that the mother opens up and talks about intrusive thoughts and/or suicidal ideation just as the HV realises she is needed elsewhere. Clear boundaries to the time allocated to each visit is beneficial to both the mother and the HV. It is imperative that the HV does not leave the mother in a worse mental state than before the HV made contact.

VISIT	COGNITIVE –BEHAVIOURAL TECHNIQUES	SELF-CARE / CAREGIVING	HAPPINESS TASK
2	Behavioural activation	Sleep	Three good things
3	Structured problem-solving	Nutrition	Acts of kindness
4	Stress-busting strategies	Exercise and fresh air	Savouring positive experiences
5	Managing relationships	You and your baby	Showing gratitude

EWVs is the descriptive term for a package of care, comprised of 6 weekly visits, that is designed to maintain and promote family emotional wellbeing. Although it is intended to improve outcomes for all members of the family, the initial focus is on maternal emotional wellbeing. This is because it is the mother who has experienced the greatest demands on her physical and mental resources, having created and given birth to a new human being. In many cases, it is also the mother who is solely responsible for providing the nourishment, in the form of breast milk, that the baby needs to grow and thrive. Wellbeing can be understood as how people feel and how they function, both on a personal and a social level, and how they evaluate their lives as a whole. The purpose of the intervention is to identify and address any factors in the mother's life that might be affecting her emotional well-being, with the expectation that promoting maternal emotional wellbeing will have a beneficial impact on all members of the family.

9.3.3.1. FIRST VISIT

GETTING STARTED – CHECKING TIME FOR VISIT

Good morning/afternoon. Whatever your usual/appropriate greeting is . . .
If you have not had the chance to check that it is still OK for you to visit in the last 24 hours it might be appropriate to ask . . .
Is it still convenient for me to visit you now?
The visit normally takes about an hour. Is that OK with you?

I'll let you know when we only have 10 minutes left in case there is anything vital that you want me to know before I leave.

> **NOTE:** Now that you have said this it is very important that you actually do what you have said so makes sure that you keep an eye on the time throughout the session (not too obviously though so it looks as though you are counting the minutes until it is time to leave!) Then provide a ten minute warning before you summarise the content of what you have covered and what you have both agreed will happen in the future. This visit is very important because it sets the foundation of everything that follows so the summary at the end should include:
>
> - a shared understanding of what the issues or difficulties are that this mother is experiencing, including how long she has been experiencing them and how they affect aspects of her life including her relationships with others.
> - How the mother will know that she is feeling better. What goals does she want to achieve, what outcomes does she hope to see?
> - A plan of action for how those goals and outcomes are going to be realized.

How are you today? How have you been since we last met?

PURPOSE OF VISITS/BEGINNINGS AND ENDINGS

I was wondering if it might be helpful just to recap on the purpose of these visits and what you can expect from them?

We have set up 6 visits because it might take a while for us to get to know each other a bit better so that you feel able to share what is on your mind and so that we can make sure that we find the solutions that are right for you. It is also good idea for us both to have a clear idea of a beginning and an ending because sometimes when you're busy or you are feeling overwhelmed, it is good to know that you have got something in place every week. For some mothers, it gives them a sense of order and control.

But of course, you can cancel the sessions if you feel that they are not being helpful or we can reschedule any sessions if we need to. We can change how often we meet and how long the sessions are to suit your needs. I will do everything I can to keep our appointments and arrive on time but sometimes emergencies crop up so I might have to reschedule the visit, but I will always let you know if I have to do that and give you as much notice as I possibly can.

CURRENT MENTAL STATE

So . . . during my last visit we identified that you were experiencing a combination of symptoms that were having an impact on several areas of your life. OR we discovered that you were experiencing symptoms of depression and/or anxiety that were getting in the way of you doing the things you wanted to do.

I am not sure if I gave you enough information about the wide range of psychological symptoms that mothers might experience during pregnancy or in the year after they have had a baby. Would you like any more information? What would you like to know?

Some mothers say that the questions that they are asked are too focused on depression, and the symptoms that are described on the checklists do not adequately describe how they are feeling. Is that true for you?

Some people want to have a definite diagnosis regarding what is wrong with them, but other people don't want to be labelled. The truth is that often people have a mixture of symptoms. For example they might have some symptoms that are typical of depression, some that are typical of anxiety, or Post Traumatic Stress Disorder, or Obsessive Compulsive Disorder . . .

Or they might have symptoms that don't fit into any of these categories. For example some mothers say that they feel very irritable, or angry, or frustrated, or they just feel out of sorts, not themselves, or sort of remote or disconnected from life and their baby.

We've talked about some of the symptoms that you have been experiencing but is there anything else that you would like to tell me about to-day?

Are there any other symptoms that you are experiencing that would give me a better picture of how life is for you?
How long have your symptoms been going on?
When did you start feeling that way? Do you know why you started feeling like that?

Was anything particularly stressful or worrying happening in your life at the time?
Was that the first time you felt like that or have you felt like that before?
Have you ever had any mental health problems in the past?
Did you have any treatment?
Was it helpful?

PRACTICAL AND EMOTIONAL SUPPORT

Do you think the way that you are feeling is affecting your relationships with others?
Have you told anyone else that I was coming to see you to-day?
Have you talked to anyone else about the way that you are feeling?
It might be a good idea if you feel able to talk to someone because one thing we know that makes a big difference to the way mothers feel is practical and emotional support from loved ones.
Do you think you would be able to talk to someone?
Who would you talk to?

> **NOTE:** Humans are designed to be sociable. It has been argued that social connection is as important as shelter and food for health and well-being **(LIEBERMAN 2013)**. Perceived loneliness ranks among the top risk factors for mortality alongside smoking, obesity, lack of exercise, excessive alcohol consumption and environmental pollution **(LUO ET AL 2012)**. Mothers with postnatal depression may experience 'unbearable loneliness.' **(CHENG, FOWLES AND WALKER 2006)**.
> It has been suggested that cultivating healthy relationships should be a public health priority **(HOLT-LUNSTAD AND SMITH 2012)**. Mothers who receive high levels of social support, instructional support, emotional support from family friends and health professionals report higher levels of confidence in their parenting role **(KHAJEHEI AND LEE 2017)**.
>
> A Norwegian longitudinal cohort study involving more than 50,000 women recruited during pregnancy found that relationship dissatisfaction was the strongest predictor of maternal distress compared with 37 other variables **(RØSAND ET AL 2011)**. Of the 8 factors that women in South East London study described as essential to their recovery, 3 of them related to improved communication with, and support from, their partner **(DI MASCIO ET AL 2008)**.

ADDITIONAL HELP IF NEEDED

If you still feel that extra help of some sort would be beneficial at the end of the sixth session, we will be able to think together about what you want to do next. At any time you might want to access additional sources of help, and that is absolutely fine too, but it is also important that you don't feel pressured to do anything you don't want to do and that you decide, if and when, you want to try something different.

It also might be a good idea if I let your GP know that you are experiencing some tough times at the moment just so that he is prepared if you go to see him and it won't be so difficult to tell him how you are feeling if he already knows. Would that be alright with you?

GOALS

The ultimate goal is for you to feel better. I will ask you to complete the same assessment forms at the sixth session that you completed at my last visit so that we can see what progress has been made.

Does that sound OK to you? Do you have some idea of what your goals might be or how you want things to be different? What do you hope to get from these sessions? How will you know that you are on the road to recovery? How would you know that you are feeling better? What would be your idea of a successful outcome? What are you aiming or hoping for?

> **NOTE:** Make sure you make a note of what the mother is hoping for/her measures of success. You may find it helpful to use an exercise book to record important points from these sessions and leave it with the mother between sessions so that she can revisit whatever was written down during the session and can write down anything that has arisen for her during the week or anything that she would like to discuss at the next session. It might also help her to share her thoughts and feelings with her partner. If such a book is used it is important that the purpose of the book is clearly stated at the beginning and that it belongs to the woman so is also hers to keep at the end.

The visits are all about us sharing our expertise – of course you are the expert regarding everything to do with your own life so you will have your own thoughts and beliefs about what has led to you feeling the way you do and what might help you to feel better or what you are willing to think about or try.

My expertise is in understanding a bit about mental health problems in general, what might be some of the reasons that some women experience them and what has helped women to feel better. I am trained in some specific therapeutic techniques that have worked with other mothers. I know what other kinds of help are available if you want to explore other options of support. Research has shown that people with mental health problems get better quicker with some kind of help than if they are left to deal with their problems on their own.

ROAD TO RECOVERY

Have you had any ideas about what might help you to feel better?
It doesn't matter if you don't but it is very important that we have a shared understanding of what it is that you are experiencing, what your symptoms are, how they are affecting your life, what outcomes or goals you want to aim for, and then a plan of action for what we are going to do to help you to feel better.

Sometimes it is hard to keep motivated and to keep going when you encounter challenges or setbacks along the way. So by agreeing to talk about how you are feeling you have taken the first step on the road to recovery. Sometimes people who experience depression (or any other kind of emotional turmoil or psychological difficulty) feel as though they have got stuck in a rut and can end up feeling fed up about everything.

You might remember that one of the questions that you have probably been asked quite a lot is whether you have been bothered by loss of enjoyment or pleasure in things. If you are not enjoying the things that used to give you pleasure or that you used to look forward to it is sometimes difficult to feel motivated about anything and that might include taking the steps necessary to help you to feel better.

On the other hand if you feel worried or anxious about a lot of things sometimes your worries overwhelm you and you can't seem to focus on anything or do everything that you want to do. That's why it is sometimes helpful to have someone who can travel on the recovery journey with you to provide support and encouragement and alternative ideas if something that you have tried doesn't seem to be working.

PREFERRED INTERACTIONAL STYLE

You might have seen the campaigns saying things like 'It's good to talk' or 'let's talk' and you have probably heard people talking about 'talking therapies'. Talking really does seem to help.

Everybody is different – some people find it helpful just to talk whilst the other person listens and some people prefer a more directive approach with the other person making some suggestions . . . do you have a preference about what might be most helpful for you? It doesn't matter if you don't . . . sometimes it takes a little while for us to get used to each other so you might not know what you want or prefer just at the moment. Some people like a combination of approaches. But please feel free to tell me if you are not happy with how things are going or if you have any suggestions about what you might prefer.

> **NOTE:** A survey of mothers' views of clinician interactional style in the treatment of perinatal depression found that as well as evaluating whether they felt 'listened to'; whether they could trust the clinician; whether the clinician had the technical competence to be able to help; and whether the treatment chosen was appropriate to their needs and they understood what was involved, the mother's response to the clinician and motivation to engage with treatment was also dependent on whether the clinician responded to their preference for either a mainly supportive or a mainly directive approach **(HENSHAW ET AL 2011)**.

STRUCTURE OF VISITS

At the start of each session we will recap on how you are feeling and how the previous week has been for you. Then we will decide together what you want to focus on for that session. I say 'we' only because it is really up to you to decide, but it is also my job to make sure that what we end up talking about doesn't make you feel as though we are not making any progress. And also, because if you are feeling low or anxious sometimes it is difficult to think straight and then you might not know what you want to talk about until we start talking.

So I will always have some ideas about things that you might want to talk about, or try out, or at least a place to start. For example, for each session I will have information about an activity that might be helpful, something around looking after yourself that will help you to feel better and some 'happiness tasks'! That might sound a bit quirky but there is a lot of evidence to show that if we persuade our brain to concentrate on happy thoughts or things that make us feel good then it stops our brains from focusing on all the things that might be making us feel stressed, worried or depressed.

Sometimes, it is hard to get started with talking about what's on your mind and it can also be very frustrating for a session to come to an end just when you feel like you are just beginning to talk about important things. So, it is my job to make sure that we limit the session to the time that we agreed at the beginning and that we have some time at the end to make sure that we have a chance to think about the things that you have shared with me. We might explore some ideas about what you might want to think about or do before we meet again. If there is anything really important that has come up and that we haven't had time to discuss properly, we can decide between the two of us on the best course of action. You won't have to talk about anything that you don't want to and you decide what you want to focus on. Does that sound OK with you?
Do you have any questions about what we have talked about so far?
Have I given you enough information about what this intervention is all about?
From what you've heard so far, do you think these visits might be helpful?

ENDINGS

NOTE: Ten minutes before the end.

So, we've just got ten minutes left.

Is there anything else that you would like to talk about to-day? Or is there anything that our discussion has made you think about that you would like to talk through when we meet next week. We can make a note of it in the book, Or, I will make a note of that so we can consider it next week (if you haven't got a book). If you think of anything between now and next week don't forget that this book is yours to write in (if you have given her an exercise book).

NOTE: Then you need to provide a summary.

So I think what we've agreed on to-day is that you are feeling . . . and you've been feeling that way for . . .

The main things that you are concerned about are . . .

You'll know that you are feeling better when . . .

So together we've agreed that the best plan of action is . . .

NOTE: Different research studies have either advocated that talking about child care practices should be included in the package of care **(SEELEY ET AL 1996, APPLEBY ET AL 2003)** or definitely not included **(MORRELL ET AL 2009, SHARP ET AL 2010)**, Surveys of mothers indicate that the way they feel is inextricably bound up with their experience of birth, breastfeeding, relationships and looking after the baby so it is important to let mothers talk about whatever is on their minds. Talking about sources of stress might also provide an opportunity for you to think through with the mother what might be helpful to alleviate that stress. Keep in mind that some of the challenges in looking after the baby might be related to the baby's response to the mother's emotions. (See section on the mother-infant relationship for more information).

It might be helpful to suggest to the mother that you plan to leave the exercise book with her so that if she wants to write anything in it – it can be her thoughts, or a reminder to do something, or anything that she wants to remember to tell you at the next session. It might be an idea if she starts writing things in from the back so that information about the visits can be recorded sequentially from the front. In this way both you and she have something to refer to at each session and can see the topics that have been covered and the progress that has been made. If she could keep it somewhere safe and bring it to all the sessions it will serve as a useful record of the work that you have done together.

Are you happy for me to come again next week on . . . at . . ?

Great – I'll see you then

9.3.3.2.THE SECOND VISIT

PREPARATION

NOTE: At the beginning of every visit it is always courteous to check that the time that you are visiting is still convenient and that the amount of time that you have allocated to spend with that mother is still acceptable. It is important (though probably very difficult) to keep to the times that you have agreed.

If you are going to be very late obviously it is courteous to let the mother know and see what she wants to do – if you are going to be late and then only have a limited time to see her (and not the full hour) you should let her know that. If you are going to be late but could still offer the hour you should make that clear because that might not be convenient for her. She might have been planning to go somewhere as soon as the session with you had ended if it had finished at the expected time.

If only a shortened amount of time is available the mother may prefer to re-schedule the visit for another day as there is a certain amount of emotional labour involved on her part and she may not want to feel rushed or feel that you will be feeling 'rushed'!

If you do have to reschedule the appointment try to make it as soon as possible as too long a delay is likely to undermine the mother's confidence. As many people discontinue therapy after just one session it is also important not to sabotage her chances of continuing working with you by your lack of availability.

There are a range of thinking errors associated with mental illness such as catastrophising; black-and-white thinking; overgeneralisation; fortune-telling; mind-reading; mental filtering; disqualifying the positive; labelling; emotional reasoning; personalizing; demanding; and low frustration tolerance **(LARSSON, HOOPER AND OSBORNE 2015).**

It might be that the mother interprets your failure to turn up when you said you would as somehow her fault or that you are making excuses because you don't really want to see her again or you are trying to cut the time short because you don't really like her. These are all only hypothetical suggestions and probably not what the mother might be thinking at all in these circumstances. Just be aware of all the possibilities.

Following the format that was agreed at the first visit you need to ask the mother how she is, how the last week has been, how she got on with the tasks she agreed to do, if she has written anything in the book that she wants to talk about and/or if there is anything particular she would like to talk about at this session. If at the end of the last session you both agreed that there was something that needed to be covered then you need to mention that and ask the mother if she would still like to talk about that issue during this session. Whatever it is it might have been resolved in the previous week or other things might have taken priority.

If the mother does not want to talk about anything in particular or wants to go to your three suggestions then you can proceed to offer the 3 options for to-day.

I do have my three suggestions of things we can think about to-day. Sometimes when you feel low or anxious you stop doing the things you enjoy doing (like seeing friends, going out, buying flowers) and stop doing the things you ought to do (like paying the bills or doing the ironing) So the first suggestion is about putting some pleasurable activities back into your life; the next suggestion is about strategies to get more sleep and the third is about thinking positive thoughts. Which activity would you like to try first?

NOTE: Offering the mother choice gives her a sense of control over the session that is very important when she might be feeling out of control in other parts of her life. Offering choice is also important because different people respond to, and refer, different things. Framing the question in the form of a choice rather than in the form of opting out (as in 'Do you think you might like to do one of these activities) is creating the expectation that the mother will choose one of them. Of course she can choose not to choose any of them if she wants to. By briefly describing all three before you start might stimulate the mother's interest in finding out what all of them are about.

Depending on how much time you have spent talking about other things there may not be time to do all these things so make sure that you leave enough time to allow ten minutes at the end to summarise what you have done, discuss what the mother might like to do between now and when you see her next time, and to plan what you might want to cover at the next session.

SUGGESTED ACTIVITIES: BEHAVIOURAL ACTIVATION

You said that you are not able to enjoy things as much as you used to – that often happens with depression – life sometimes feels as though it has lost its colour. One of the things that we know helps people who are feeling low to feel better is to increase their activity levels. That doesn't necessarily mean exercise although exercise does help.

It might be an idea to start with making a list of the things that you could do that would make you feel better. It could be just simple things like allowing yourself time to read a magazine, phone a friend, pamper yourself, or go for a walk or it might need more planning like going swimming or going to a movie . . . we could make a list right now and then you could decide what you are going to treat yourself to between now and when I see you next week.

Some mothers have found it helpful to make a list of pleasurable activities that they are going to and then keep it on the inside of a cupboard door in the kitchen (or anywhere else) so that they can be reminded of all the pleasurable activities they have to look forward to (which also makes you feel good) and they can tick them off as they do them or put dates by them when they plan to do them.

It is also important to not end up feeling overwhelmed by all the things you know you have to do. So as well as thinking of something to do that makes you feel good it might also be helpful to set yourself the task of doing one thing that you know needs to be done. Having the sense that you have achieved something will also make you feel better.

SLEEP

A common challenge for all mothers is having to cope with disrupted sleep and just feeling tired all the time. Sleep is as important to our bodies as eating, drinking and breathing and vital for maintaining optimal mental and physical health.

Most of us don't get the recommended 8 hours a night. During pregnancy and after having a baby is just the time when your body needs a lot more sleep because there is a lot of growing and repairing to be done. The trouble is that it is also a time that you have to manage on a lot less sleep than you are used to. Most women get an average of about 6 hours sleep during a 24 hour period and some get a lot less than that. What are your nights like? How much sleep do you get on average do you think?

We all know that when you are exhausted you just can't think straight. Disrupted sleep can be both the cause and consequence of anxiety and depression. So, one of the things that might help you to feel better is if we can think of some strategies that might help you to get more sleep. Do you think that would be helpful? Shall we talk about sleep?

> **NOTE:** 'Patients who are deprived of sleep have been shown to have reduced alertness, shortened attention span, decreased reaction time, poor judgment capacity, reduced awareness of the environment, poorer decision-making skills, poor memory, and reduced concentration.' **(YEGNESWAREN 2007 P.569)**. Sleep deprivation also leads to heightened sensitivity to pain **(FARAUT ET AL 2015)**. Studies have shown an association between disturbed maternal sleep and the subsequent development of postnatal depression **(DENNIS AND ROSS 2005; GOYAL ET AL 2009)**.

Do you find it easy to get to sleep?
Can you sleep when your baby sleeps?
Do you find it difficult to stay asleep?
About how many times a night do you wake up?
Is it always to feed the baby or do you wake up at other times as well?

Do you dream a lot? Or maybe have nightmares?
Do you find yourself waking up early in the morning even when the baby doesn't wake you up?

When you wake up in the morning do you feel rested? (Or is that a silly question?!)
Do you manage to get some catch-up sleep during the day?

> **NOTE:** Difficulties in falling asleep, maintaining sleep or waking early are typical symptoms of depression **(NUTT, WILSON AND PATTERSON 2008)**. Difficulties in falling asleep can also be symptoms of anxiety and PTSD. People suffering from PTDS also have difficult staying asleep and frequently have nightmares **(MAHER , REGO AND ASNIS 2006)**. Recollection of increased dreaming (or nightmares) can also be a sign of psychological problems. It means that the person is spending a disproportionate amount of time in REM sleep (the sleep when you process your emotionally arousing experiences from the previous day). Dreaming uses up a lot of energy leaving insufficient energy for the next day so the person wakes up feeling tired and lacking motivation **(GRIFFIN AND TYRELL 2003)**.

Before we start exploring some ideas about what might be helpful to get you more sleep so that you feel less tired, we just need to check that there aren't any physical causes of your tiredness. Some women have low Haemoglobin or ferritin levels which means it might be lack of iron making them feel tired OR they might have some underlying infection or source of inflammation that is making them feel exhausted.

Do you think either of those might apply to you? Have you had a recent blood test? Have you recovered physically from the birth? Did you lose a lot of blood during or after the birth? Have you got any left-over aches and pains?

> **NOTE:** In a meta-analysis of the predictive factors of postpartum fatigue **(BADR AND ZAUSZNIEWSKI 2017)** physiological illness, low ferritin level, low haemoglobin level, sleeping problems, stress

and anxiety and breastfeeding problems had a moderate effect on predicting postpartum fatigue. Depression had the largest effect on predicting postpartum fatigue. This same study estimated that 64% of new mothers experienced postpartum fatigue.

It is also important to find out about physical health problems. Physical health problems may include headaches, back pain, perineal pain, mastitis, haemorrhoids, urinary and faecal incontinence, lack of sexual desire and painful intercourse **(ANSARA ET AL 2005: WOOLHOUSE ET AL 2014)**. Several studies have found a relationship between persistent physical/sexual health problems and depressive symptoms up to 4 years after delivery **(BROWN AND LUMLEY 2000; GIALLO ET AL 2017)**.

Do you have any ideas about how you might be able to get more sleep?
Of course there are probably lots of things that might be helpful.
It depends on what is causing the problem.

The main issue is usually to do with having to get up so many times in the night to feed the baby. Is that the case for you do you think?
Babies do seem to take a while to adapt to the day/night cycle that everybody else follows. A lot of babies do seem to have their days and nights completely the wrong way round so they have their longest sleeps during the day and their shortest sleeps and fussiest times during the night. Is that how it is for you?

Can we talk a little bit about your baby's sleeping/feeding habits?
Is there any sense of a routine developing?
Are the gaps between feeds getting a little bit longer sometimes?
Does your baby drink more or less milk at certain times of the day?
Does he/she seem to be hungrier at certain times?

Some mothers say that the baby seems to always want to feed whenever they sit down for a meal! Do you find that? If that is the case – how is that for you? How do you manage?

Do you have a particular routine at night-time?
Where does the baby sleep?
Dose he/she sleep in a different place for their night-time sleeps?
Does that make a difference to how well they sleep?

Have you noticed that your baby sleeps better or worse in certain places or in association with certain things that are happening around them?
Some strategies that have been found to be helpful to encourage babies to adapt their sleep patterns to the family routine include:

- Making the difference between day and night more obvious. Our bodies make a sleep hormone called melatonin as it gets dark and then production of it decreases as it gets light again. Most babies ability to make melatonin takes a while to develop (about 12 weeks). Even so, babies are still receptive to time cues. It is a good idea to reduce stimulation at night (noise, light) and expose babies to daylight during the day. It is also good for mothers to be exposed to daylight especially in the morning as this clearly signals the difference between day and night to their internal body clock. Making a point of taking the baby

out for a walk each morning at more or less the same time may help both the mother and the baby with their daily rhythms and can have other benefits too. Light on the skin stimulates the production of beta-endorphins which are responsible for relieving pain, promoting relaxation, healing wounds and growing new cells **(BAGGERLEY ET AL 2015)**.

- Keeping babies amongst the hub-bub of family life during the day.
- Infant massage, bath, reading or lullabies as part of the initial going to sleep routine to signify the border between day and night might help the baby to relax into a longer sleep at night and provide a useful marker of day/night difference.
- Breastfed babies benefit from the levels of maternal tryptophan in breastmilk. Breastmilk also contains the hormone oxytocin which has a calming effect. Tryptophan is used to make melatonin in the body. Infants who are breastfed tend to fall asleep faster and sleep for a longer amount of time overall during the night. If mothers are expressing breastmilk, they need to make sure that they are giving milk that was expressed in the evening, to their babies in the evening (if possible).
- DHA which occurs naturally in breastmilk also helps infant sleep. Some formulas also contain DHA.

Do you think you might find any of these strategies helpful? Which ones do you think you might like to try between now and next week?

NOTE Mothers who reported frequent night-time wakenings of their infant at 1 week were more likely to show signs of depression at 4 and 8 weeks postpartum **(DENNIS AND ROSS 2005)**. Interventions aimed at improving infant sleep in order to improve maternal mood have had mixed results **(DOUGLAS AND HILL 2013)**.

A small RCT (n=54) to test the effectiveness of an intervention to prevent postpartum depression by targeting maternal management of infant sleeping and crying found that the intervention was well tolerated and reduced maternal symptoms of anxiety and depression. The intervention was developed in America and is called 'Practical Resources for Effective Postpartum Parenting.' **(WERNER ET AL 2016)**.

NOTE: Disruption in circadian rhythms is associated with depression **(WALSH ET AL 2014)**. The following studies highlight the benefits of light.

A systematic review and meta-analysis of the effect of light therapy on non-seasonal depression found that although the quality of the included evidence was poor that, given the low cost and limited side effects, and the fact that a significant proportion of patients experienced a clinically significant response benefit, light therapy is an effective treatment for depression **(PERERA ET AL 2016)**. In a 5-week randomized, double-blind, placebo-controlled study of light therapy for pregnant women with nonseasonal major depressive disorder, a statistically significant difference in remission from depression was attained by 68.6% of women in the intervention group compared with 36.4% of women in the control group **(WIRZ-JUSTICE ET AL 2011)**.

A study of full-term infants exposed to afternoon sunlight demonstrated that they slept better at night **(HARRISON 2004)** Babies who get outside experience higher levels of light (but obviously care needs to be taken when it is very hot)and adapt more quickly to the day/night cycle **(TSAI ET AL 2012)**.

We have talked about some strategies that might help the baby to sleep better and they might have a knock-on effect for you as well but there are other things that you also might like to try:

- Taking a 30-minute nap during the day. In one study where volunteers were only allowed to sleep for 2 hours a night, 2 x 30 minute naps the next day helped to over-ride the negative effects of sleep deprivation **(FARAUT 2015)**.
- Lying down and resting (with your eyes closed) even if you don't fall asleep. Lab studies have shown that some people fall asleep without realizing it and if you fall asleep long enough to go into the second stage of sleep for just three minutes then this has a recuperative effect. **(HAYASHI ET AL 2005)**.
- If you find it difficult to sleep during the day consider asking a member of the family or a friend to be around and to take responsibility for the baby if they wake up. This might help you to sleep better.
- Practise relaxation exercises to help you to feel less tense.

> **NOTE:** See the Psychosocial assessment chapter section 1.1.18 for some suggestions.
> 5 Give yourself a relaxing bath to coincide with your baby's longest sleep period to increase the chances of both of you having your longest sleep at the same time.
>
> Do you think any of these strategies would work for you? Would you be willing to try at least one of the before I see you next week?
>
> **NOTE:** A Tiredness Management Guide developed for mothers experiencing postpartum fatigue describes 8 potential sources of fatigue: (1) infection, (2) lack of rest during the day, (3) pressure to "get everything done"(4) interruptions in night-time sleep, (5) pain, (6) stress associated with new roles, (7) anaemia, and (8) social activities **(TROY AND DALGAS –PELISH 2003)**. Strategies to combat fatigue depend on the cause. For example, if the source of fatigue was the pressure to get things done – some of the possible solutions might be to think about what are the things that need doing, who else can help to get those things done or how important is it that all those things get done.

HAPPINESS TASK – THREE GOOD THINGS

Sometimes it is hard to think about the good things in life when you have a lot of things to cope with and you don't feel very positive. The trouble is we have a natural tendency to focus on all the things that are going wrong rather than some of the things that are going right.

It has been shown that thinking positive thoughts can change the way you feel. One strategy that is recommended is, at the end of the day, to think of three good things that went well for you during the day or three things that you have to feel grateful for. In tests, people who tried thinking of three things that they had to be grateful for every night for a week were happier and less depressed one month, three months and six months later.

There is an app that helps you to do this if you are interested – it is called The Gratitude Garden (or you can just do it in your head! Or some people find writing it down is helpful).

Do you think you could commit to doing that every night for the next week and then let me know how you got on when I see you next?

NOTE: Fredrickson (2001) proposed the 'Broaden-and-Build' theory of positive emotions based on the premise that positive emotions broaden people's thinking and attention, encouraging creative solutions to problems and an urge to act, play and explore. If a conscious decision is made to think about something positive this also helps to disrupt the predisposition to think negative thoughts.

ENDING THE VISIT

NOTE: Make sure that you have kept an eye on the time throughout the visit and can let the mother know 10 minutes before the visit is scheduled to end.

We agreed that this session would end at . . . so our time is nearly up. We have just another 10 minutes left. Before I go is there anything that you would like to tell me?

So, we've talked about quite a lot of things to-day and I think you have agreed to try out some strategies between now and next week. I think what you have agreed to do is . . .

Sometimes it helps to specify exactly when you are going to put plans into action. Otherwise things just keep getting in the way and then the week has flown by. Remember these little steps are all going towards achieving your main goal of feeling better. So, when do you think you might be able to do the things you said you were going to do?

NOTE: Of course you may not have had time to cover any of the three suggestions as the mother wanted to talk about other things in which case you also have to be very aware that you must not leave the mother in a state where she has poured out all her worries and concerns to you and the session has come to an end without any sense that things will get better. Remember that instilling hope is a fundamental component of recovery. So you need to make sure that you have spent some of the time encouraging the mother to think about what might be some helpful things for her to do between now and next week. It is very important that you do not leave the mother feeling vulnerable and exposed.

NOTE: If you are using an exercise book to record the sessions you could offer at this point to write in the book the things that the mother has agreed to do between now and next week. It might be helpful to suggest to the mother that you plan to leave the exercise book with her so that if she wants to write anything in it – it can be just her thoughts, or a reminder to do something, or anything that she wants to remember to tell you at the next session. It might be an idea if she starts writing things in from the back so that information about the visits can be recorded sequentially from the front. In this way both you and she have something to refer to at each session and can see the topics that have been covered and the progress that has been made. If she could keep it somewhere safe and bring it to all the sessions it will serve as a useful record of the work that you have done together.

Is there anything that you would like me to make a note of . . . for us to start thinking about at the beginning of the next session?

Is it still OK with you if we meet next week on . . . at . . .

Great – I'll see you then.

9.4. Discussion

It was clear from respondents to the survey (Chapter 7) and review of the literature (Chapter 6) that HVs were unsure about what they should be doing to support mothers with MHPs and wanted a manual to guide their practice. As part of the process of the identification of core components of effective interventions (Chapter 4), I contacted study authors to request copies of their manuals if insufficient information about the components of the intervention was included in the retrieved article. I also conducted an on-line search for manuals used by health professionals to support mothers with perinatal MHPs. As facilitated self-help superseded LVs as the recommended intervention for mothers with mild to moderate anxiety or depression in the updated NICE guideline, I also retrieved and examined manuals that enabled health professionals to provide guided self-help, or were self-help manuals that mothers could access and use.

My requests resulted in the acquisition of several manuals that varied in content, length and purpose. I acquired the manuals specifically designed to aid HVs in their delivery of LVs from one of the authors of the study that introduced the concept of LVs **(HOLDEN ET AL, 1989)**; the research HV involved in delivering LVs in the Cambridge study **(COOPER ET AL, 2003, MURRAY ET AL, 2003)** and the manuals used in the PONDeR trial to guide HVs in using either a person-centred (PCA), or cognitive behavioural approach (CBA) **(MORRELL ET AL, 2009)**. With regard to the manuals to facilitate the delivery of LVs, some also included how to use the EPDS in order to determine eligibility for the visits.

The manuals for LVs guided by PCA/NDC were much briefer than those that included cognitive behavioural techniques or included consideration of the impact of maternal mental ill-health on the mother-infant relationship. Whilst acknowledging that they were supposed to explain how support should be provided I was surprised at the variations in depth of description and explanation.

Smythe and Spence (2012) talk about the importance of 'leaning in' to literature that captures attention and provokes thinking. During my hermeneutic exploration of the literature I was also struck by phrases in two articles that seemed to me to be important in relation to my thinking about how to produce a manual. The first was 'Unknowing.' This was related to the role of mental health nurses and the value of not prematurely assuming to know what a person's problem was, or the best way to help, in order to allow a more authentic understanding of a person's experience to emerge over time **(LAKEMAN, 2014)**. This is why I felt it was important to list the key clinical activities at the beginning of the manual to highlight the skills and qualities that HVs need to explore maternal symptoms, experiences and circumstances, without seeking to match their symptoms to diagnostic criteria. The formation and maintenance of a trusting relationship also relies on the establishment of a bond between the HV and the mother and the need for the HV to clearly describe her role and remit. The explanation of the importance of the foundations for an effective therapeutic alliance was not addressed in many of the manuals that I reviewed. It is also why the guide is described as an integrated assessment and intervention framework to emphasise the importance of ongoing assessment. Although the sections on assessment, psychosocial assessment, psychoeducation and providing support are presented as separate entities it is expected that the components of each section will be integrated with each other.

The second phrase that shaped my thinking about how to present the format of the manual was 'gifts not tasks' **(VIK & RHODE, 2014)**. This was written in an article about helping mothers with postnatal depression to tune into their baby's needs but it made me contemplate how the manual could be more than just a list of 'tasks.' I hypothesised that that HVs would like to know not only 'how' to support mothers with

MHPs but 'why' they were doing what they were doing, hence the reason for the infiltration of the evidence underpinning the statements and questions throughout the text. HVs also wanted to be assured that they were offering an updated, evidence-based intervention and this seemed to be an excellent way of encouraging them to ask the questions in response to the underpinning evidence.

The section on providing support emphasises the importance of structure in the context of the whole intervention as well as the format for each visit and demonstrates the importance of negotiating a therapeutic contract. Although the focus of the intervention appears to be on the suggested strategies and techniques related to symptom reduction, self-care/infant care and emotional wellbeing, the emphasis is always on the exploration of how the mother is feeling and her beliefs about what might help to facilitate her recovery. Addressing any issue that affects maternal psychological wellbeing is considered an effective use of HV time. This might include issues around breastfeeding, partner relationships, housing issues or money worries.

The WHO report on effective interventions to prevent mental disorders refers to the strong evidence suggesting that it is the 'cumulative effect of the presence of multiple risk factors, the lack of protective factors and the interplay of risk and protective situations that predisposes individuals to move from a mentally healthy condition to increased vulnerability, then to a mental problem and finally to a full-blown disorder' **(SAXENA ET AL, 2006 P.6)**. Risk factors for mental illness may also contribute to poor physical health, compromised relationships, social exclusion and emotional and behavioural problems in children. By counteracting risk factors and reinforcing protective factors as early as possible in the perinatal period health visitors have the potential to make a significant contribution not only to the prevention of mental illness but also to contribute to better physical health and socioeconomic outcomes for all members of the family.

9.5. Strengths and Limitations

This EWV intervention has been developed as the result of following each stage in the enriched development phase of the MRC guidance for developing and evaluating complex interventions recommended by Bleijenberg et al (2018).The systematic approach has enabled an investigation of LVs from multiple perspectives. However, it is still inevitable that the end product is influenced by my interpretation of all that I have discovered and how I have blended that new knowledge with my own experience, beliefs and expectations. Writing the 'guide for practice' in the form of a script is a further illustration of my personal and professional influence on the end-product and I am acutely aware of the resistance that such a definitive act can potentially generate. As a text, without explanation and discussion about how it came to be, and the inherent limitations of its content, there is a risk that the EWV guide will be dismissed without further testing in practice. Although there are disadvantages to producing the guide, I am also aware that without a concrete end-point to act as a springboard for further lines of inquiry there is a risk that all the thinking that I have done, all the knowledge that I have accumulated and the wisdom that I have accrued will just be 'lost' in the library of written, but not read, PhD theses.

Gadamer maintains that what one says does not constitute a definitive given reality, neither is what somebody else says, or thinks, a definitive given reality. The trouble is that when words are written down they risk creating the illusion of permanence. The hope is that participants in any kind of dialogue (with a text or with a person) will be able to think beyond what is presented to them, and what they

already know, in order to come to a new understanding. Hermeneutics is the art of being able to listen, to overcome the prejudicial effects of individual 'historicity' to let something else be said, to let a new perspective settle in one's consciousness and to be willing to investigate the possibility of thinking, speaking or acting in a different way. Whilst Moore et al (2019 p.34) suggest that 'resistance to the introduction of a disruptive change is to be expected,' Hawe (2015) argues that 'minimally disruptive' interventions that are accepted and easily accommodated by clinicians may not produce an observably beneficial effect. Many of the strategies and techniques proposed in the EWV intervention are familiar to many HVs and are already part of their salutogenic repertoire. Interventions are more likely to be adopted if they are not too disparate from existing practice but also may be disregarded because there is no perceptible difference between the 'new' and the 'old'. There is a possibility that the EWV guide for practice may be resisted both because it is perceived as disruptive or because it is not disruptive enough!

This is only the first version of the proposed intervention. O'Cathain et al (2019) in their guidance on how to develop complex healthcare interventions suggest that intervention development is 'dynamic, iterative, creative, open to change and forward looking to future evaluation and implementation.' (p.2). Key 'actors' in the future development of the intervention are HVs and mothers, but there are also others, such as policy-makers, commissioners, managers, educators and other health professionals whose beliefs, perceptions and actions will determine whether contextual factors enhance or impede the continuing development, testing and implementation of the EWV intervention.

My professional heritage could also be considered as a strength that may increase the likelihood of acceptance of the EWV intervention by HVs and a willingness to test, adapt and develop the guide in the future. I am proposing that a 'unique selling point' is that the guide has been developed by a health visitor (with additional expertise in mental health') with HVs and for HVs. Collaboration increases the chances of the adoption of innovations. Although I have surveyed HVs, considered the views of HVs though examination of the literature, involved HVs in the development of the guide, recruited the support of HVs to test the guide in practice, and am now working with the iHV to continue to develop the guide, it might also have been beneficial to involve HVs in earlier stages of the research so that the guide was truly co-produced. I would also have appreciated greater input from HVs into the design and format of the guide for practice although I am also aware that it might have taken time to reach agreement. My expectation is that co-production will be essential in the further development of both the guide and the training and infrastructure required to facilitate optimal understanding and implementation. There is also a possibility that the guide may not be considered appropriate or useful, in which case, other options will need to be explored.

A final point about involving HVs in the research process relates to managing expectations. I am aware that HVs who were invited to complete my survey in 2016 and heard me speak at conferences in 2016 and 2017 or participated in the Delphi Approach were hopeful that proposals for change would be imminent. Enthusiasm for the end result may have waned in the interim between then and now.

9.6. Conclusions

This chapter has described the content of the EWV guide and provide some illustrative content to demonstrate some of the fundamental principles, key messages and core processes of assessment and intervention that are included. It has also demonstrated how the guide is intended to provide clear evidence-based suggestions to help HVs identify and support mothers at risk of, or experiencing, MHPs. This guide is just a prototype and is likely to undergo multiple revisions as it is read and tested in practice by HVs. It might be adapted or discontinued over time. Whether the guide survives or not, in its current form, it is providing a focal point for discussion about what HVs should, or could, be doing to support mothers with MHPs. The guide on its own will not change practice or outcomes. A complex intervention delivered in a complex adaptive system, reliant on a complex social system, requires understanding and change at multiple levels.

A group of HVs in collaboration with the medical records department of their Trust began a quality improvement project to test the use of the guide in practice and to explore ways of recording the actions and outcomes of the HV EWV intervention. Unfortunately, progress on this project has been hampered by the Covid-19 pandemic. A further pilot project funded by HEE, and hosted by the iHV involved 36 HVs in reviewing the guide and the training. Changes have been made to both the guide and the training and a further two cohorts of HVs have been trained in the use of the guide. It is anticipated that the HVs who have been trained to use the guide will become EWV champions who will then cascade the training to their peers.

9.7. Chapter summary

This chapter has provided an overview of the EWV guide and described the process and rationale for the content and format. Strengths and limitations as well as plans for future development and implementation have been highlighted. It has been emphasised that this is a work in progress and that consultation with other 'actors' might help to improve the likelihood that it will be implemented in practice and will improve outcomes for mothers and their families.

Chapter 10. Discussion and Conclusions

10.1. Introduction

This chapter brings to a conclusion my thoughts and reflections about the design and outcome of my PhD study. The topic under scrutiny in this research was LVs and, by association, the role of the HV in supporting mothers with MHPs. In an early stage of the research, a survey of HVs revealed variations in understanding about what LVs were, what outcomes were expected and the training available. Many of the survey respondents felt that the lack of a standardised approach compromised consistent, competent perinatal mental health care and felt that what was needed was an updated, evidence-based manual to inform their practice. Before a manual could be developed it was necessary to establish whether HVs should continue to offer LVs, or an alternative intervention.

Returning to the Thirsk & Clark (2017) analogy of developing a greater understanding of the meaning of a table by gathering the perspectives of the people sitting round the table, greater understanding of the definition and purpose of LVs, or a possible alternative, is harvested from the multiple perspectives of individuals involved in designing, delivering and receiving LVs, or equivalent perinatal mental health interventions. A 7-stage research process guided by the enriched development phase of the MRC guidance for complex interventions **(BLEIJENBERG ET AL, 2018)** therefore explored multiple perspectives that helped to 're-imagine' LVs and culminated in the development of a prototype guide for practice that was intended to enable HVs to identify and support mothers at risk of, or experiencing, MHPs, and to promote maternal emotional wellbeing.

10.2. Revisiting philosophical assumptions

Gadamerian hermeneutics provides the philosophical foundation for the mode of inquiry used in this programme of research. McCaffery et al (2012 p.220) explain the meaning of what Gadamer referred to as *BIldung* as 'a cultivation of what can expand understanding of the topic, which can include not only the obvious sources (as in the conventional literature review) but also whatever cultural resources can help to shed light on the topic.' Thirsk and Clark (2017) suggest that this means that we should not be constrained by the limitations of conventional sources of knowledge but should look to gather any new, interesting or inspiring information that will expand our thinking and enhance our understanding. Gadamer also suggests that it is through understanding that the relevance to practice emerges. This knowing how to act (phronesis) is different from, though related to, knowing what things are (episteme) or how things are done (techne). In healthcare provision this translates to knowing how to apply knowledge to the unique needs and circumstances of individual patients.

Instead of seeking to obviate researcher prejudice, Gadamer maintained that it is only possible to make sense of new information in the context of what we already know. As more information comes to light we amend our understanding and continue on a cyclical journey of discovery as a result of dialogical engagement with the views of others, in text or in person **(GUZYS ET AL, 2015)**. With respect to this thesis, the dialogical engagement included the interplay between my pre-existing knowledge and experience and the findings from the aforementioned survey, a series of literature reviews, and a real-time, face-to-face, modified, technological Delphi Approach involving collaborative discussions with a group of expert HVs. It was also so much more than these concrete representations. I have found Gadamer's exposition of philosophical hermeneutics thought-provoking, inspiring and challenging. Inevitably, the 'art and science' of interpretation pervades every aspect of this thesis.

In recognition of the concept of the hermeneutic circle (the whole informs the parts and vice versa), starting with the hermeneutic literature review, this chapter will bring together the findings from the different stages of research. The summative benefits and limitations of the component parts are presented in the context of the challenges of conducting research of a complex intervention operating in a complex adaptive system, against a backdrop of a diminishing workforce and escalating maternal MHPs. The implications of the research for the future of health visiting perinatal mental health practice will be considered with particular reference to the further development and testing of the tangible end-product of the EWV guide for practice.

Smythe (2019 p.6.) suggests that hermeneutics provides the freedom to explore multiple sources of information, to 'embrace uncertainty, to drink in possibilities' in order to generate new ways of thinking and knowing. This, of course, is the purpose of a PhD: to generate new ways of thinking and knowing, in order to make an original contribution to the body of knowledge. Making an original contribution to the body of knowledge, when the body of knowledge is so vast, is a daunting prospect. However, I am reassured by the words of Mark Twain who said, 'There is no such thing as a new idea. It is impossible. We simply take a lot of old ideas and put them into a sort of mental kaleidoscope. We give them a turn and they make new and curious combinations.' **(TWAIN, 1907/2010)**. I am hoping that my kaleidoscope of ideas is original in the way that they are put together and that the 'curious combination' may still be valuable.

10.3. Presenting the case for a hermeneutic literature review

Writing in The American Psychologist in 2003, Adair and Vohra (P.2) exclaimed that 'the information explosion is upon us!' That was 18 years ago. The amount and pace of international research into perinatal mental health makes it difficult to access all the relevant and most up-to-date articles. A recent google search using 'perinatal mental health' as the search term identified over 17.2 million entries with over 4.2 million entries identified from the search term 'perinatal mental health interventions' and 11.6 million from 'perinatal mental health assessments.'

This illustrates how, in this age of limitless information, an absolute truth is unattainable because we can never know all that there is to know **(GREENHALGH & PAPOUTSI, 2018)**. Moreover, Gadamer argues that, even if we could access everything that was ever written on a subject and try to make sense of it, as we all interpret reality (and text) in the context of our past experiences, no matter how hard we try, there is no absolute truth that can be exposed by objective, scientific methods **(MOULES, 2002)**. Hermeneutics is a set of guiding principles that facilitates the human search for 'truth' by contemplating what hides behind, and what lies beyond, what is written or said. It is the interpretation rather than the method that reveals the greatest insights. With respect to literature reviews, Lipworth et al (2013) warn that an over-emphasis on methodological rigour risks excluding conceptually relevant studies. Smythe and Spence (2012) assert that 'literature cannot be regarded as objective truth to be thematised, categorised, critiqued and then pieced together to create an argument. Literature is rather a rich, complex array of meanings, all of which will be interpreted across gaps of understanding, and all of which is representative of a point of view' (p.14). Philosophy does not equate to the pursuit of method but translates from the Greek 'philo' meaning 'love' and 'sophos' meaning wisdom. One definition of wisdom is 'the ability to act using knowledge, experience, understanding, common sense and insight (dictionary.com). This thesis hopefully demonstrates these attributes.

The etymological derivation of method is meta-odos. This has been translated by Caputo (1987 p. 213) as 'the way in which we pursue a matter' and suggests a deeper appreciation of method informed by a sense of adventure rather than a set of rules **(GADAMER, 2007)**. Hermeneutic orientation implies that it is not only unrealistic, but also inadvisable, to suggest that it is possible to take an objective stance when reviewing literature, even if the most rigourous methodology is followed. There is always a point at which you have to make a decision on whether to exclude or include an article based on personal interpretation of the meaning of the words that are used, or included in the title or abstract, or decide how stringently to apply quality appraisal criteria. Alongside eminent professors such as John Ioannidis from Stanford University **(IOANNIDIS, 2005)** and Trish Greenhalgh from the Nuffield Department of Primary Health Care Sciences in Oxford **(GREENHALGH ET AL, 2018)** I too, challenge the value and relevance of conventional literature reviews, especially in circumstances where limiting the search to a clearly defined, illness, intervention and target population does not represent the reality of the clinical situation. As Faulkner (2015) argues, artificial constructions of clinical reality, such as that deployed in RCTs (and systematic reviews of RCT's), belie the complexity of human psychological and social experience, inhibit innovation, and promote a mechanistic, measurable approach to treatment and outcomes that distort the lived experience of delivering or receiving care. This is why, in an examination of any intervention, it is so important to include the views of the providers and recipients of care (Chapter 6 and Chapter 7). Whilst I have attempted to include the views of mothers and HVs, the findings nevertheless represent my own interpretation of other researchers' interpretation of what mothers or HVs have said, or in the case of the on-line survey, what HVs have written.

I propose that a hermeneutic literature review reflects what many eminent scholars do anyway, when they supplement a conventional search with citation tracking, immersion in the literature and conversations with experts. Even when reviewers meticulously follow the steps taken by another reviewer the chances are that they will not end up selecting exactly the same articles and, even if they do it is likely that they will reach different conclusions about the meaning of the articles they have selected. If they can replicate exactly what another reviewer has done and come up with exactly the same answers, I am not sure about the value of continually following the same procedure to find out the same things that someone else has already discovered.

Then there are the related issues of complexity and the nature of evidence. The emphasis on a biomedical model focuses on evidence of effectiveness of specific interventions designed to treat specific illnesses. The challenge of defining perinatal MHPs, differentiating causes from symptoms, and MHPs from the adaptive process of adjusting to parenthood, whilst appreciating that every person is unique in the way that they perceive and respond to stress, illness and treatment, adds to the complexity of defining what the problem is and the response that is needed.

It is interesting to reflect on the fact that interventions identified by mothers as preferable do not necessarily resonate with the interventions offered by clinicians and supported by research. Despite the fact that there is also evidence about interventions that improve or maintain wellbeing, these are often accorded a lower priority than more traditional interventions and may not be identified by literature reviews using specific inclusion/exclusion criteria. The propensity to argue that there is insufficient evidence to justify introducing innovative interventions favours persistent use of familiar interventions, just because there is a greater body of evidence demonstrating their effectiveness, even though they still may not work for more than 50% of the target population **(CRASKE, 2018; MORRELL ET AL, 2009)**.

There is such a complex array of intertwined physical, biological, psychological, social, economic and environmental factors that precipitate or perpetuate perinatal mental ill-health **(LEHMAN ET AL, 2017)** that all these issues may not be adequately covered by existing literature. This body of evidence is often not included in systematic reviews designed to determine the purpose or content of assessment, or the effectiveness of interventions. The diversity of interventions designed to improve maternal mental health may be considered as one entity in terms of inclusion criteria for a systematic review but then the results may be discounted on the basis of the small number of trials, unclear risk of bias, or heterogeneity of delivery mechanism, content, duration, frequency, timing and outcome measures **(ALDERDICE ET AL, 2013; CLARK ET AL, 2013; EVANS ET AL, 2018; FIRTH ET AL, 2016).**

Yim et al (2015) suggest that insufficient attention is given to the biological origins of perinatal MHPs, compared to the literature available on psychosocial influences. There is a vast, and often ignored, literature on the proposed mechanisms linking the 'extensive transformation of maternal physiology necessary to maintain the pregnancy' **(GLYNN ET AL, 2018 P.906)**, maternal antenatal circumstances and behaviour, and maternal and foetal/infant outcomes. For example, inflammation, triggered by multiple stimuli including sleep deprivation, loneliness, stress, or obesity may precipitate sickness behaviour characterised by fatigue, anhedonia, weakness and social avoidance (symptoms of depression) **(BERK ET AL, 2013; GASSEN & HILL, 2019).** Interventions addressing these underlying issues (such as sleep, stress and social isolation) might therefore contribute to the prevention and amelioration of depressive symptoms and are featured in the EWV guide for practice.

A conundrum also exists regarding how to integrate research from evidence with research from practice. Innovations may be adapted or adopted because whole organisations, teams or individual clinicians think they are a good idea and they seem to work, even though there is no robust research evidence to indicate their effectiveness and they are not reported in, or retrievable from, the literature. Laska et al (2013) suggest that it is inevitable that interventions will be adapted to different contexts and modified in the light of new knowledge and perceptions of acceptability. Chambers & Norton (2017) argue that if interventions are to produce optimal outcomes it is important to investigate how and why interventions are adapted by different practitioners to fit different contexts. The problem is that literature that describes practice developments may be dismissed because it fails to meet quality criteria even though it may convey useful messages from, and for, practice. This is why an explication of the evolution of LVs includes evidence from both RCTs and articles about practice development (Chapter 3), and Chapter 6 and Chapter 7 have provided additional information that help to enhance understanding about how, and why, LVs have changed over time. It is noted that the emphasis in the literature is slowly changing from knowledge translation (working with clinicians to translate evidence from research into practice) to integrated knowledge translation or co-production (working in partnership with knowledge users) and is moving from 'implementation science' to 'engagement science' **(GRAHAM ET AL, 2019).**

The evolution of LVs (Chapter 3) confirmed that the majority of RCTs have demonstrated clinically significant improvements in depressive symptoms for mothers receiving LVs, although at least a third of mothers do not recover. This is attributed to a number of reasons including a failure to accurately identify and address the causes and range of maternal symptoms, and confusion about whether the intervention is meant to be preventive, supportive, or therapeutic. Research suggests that mothers are also more likely to express dissatisfaction and prematurely disengage from an intervention if they do not have confidence in the skills and expertise of the health professional and the duration, purpose and content of the intervention is not clearly described at the outset **(HADFIELD & WITTKOWSKI, 2017; HENSHAW ET AL, 2011;**

SLADE ET AL, 2010). HVs cannot exude confidence in their capacity to help if they feel ill-equipped to deal with MHPs.

Adaptations to the Holden et al (1989) LV protocol have been implemented with varying degrees of success. Literature reviews of surveys and interviews with mothers and health visitors (Chapter 6) indicate that a greater depth of understanding is required regarding the range of MHPs that mothers might experience; the factors that contribute to their occurrence; the range of symptoms that signify psychological distress; the process of engagement and assessment; the treatment options that are acceptable and effective; consideration of the needs of other family members; and outcome measures that indicate clinically relevant and maternally determined features of recovery. These dimensions of maternal mental ill-health require investigation from multiple perspectives and although this study attempted to elucidate many of these parameters, the inquiry exposed how much more there is to find out that might contribute to an improvement in the way that HVs approach both the assessments and interventions they offer. There needs to be better and less cumbersome and time-consuming methods for acquiring and synthesising the information that might be relevant and useful.

In my defence of hermeneutic literature reviews I would also like to point out the many ways, besides searching conventional databases, that relevant literature can capture one's attention. For example, via journal alerts, reference management system alerts, research-gate, twitter feeds, google scholar or access to preprint servers. I have found these methods much more efficient at highlighting relevant and current information (than traditional database searching using MESH terms) although, with multiple alerts, the volume of literature can rapidly become overwhelming and unmanageable.

The landscape of information sharing and retrieval is changing. I think academics will soon have to concede that it is no longer possible to conduct a static literature review that is completed at a particular moment in time, for example at the beginning of a PhD study, and expect the gaps in knowledge so exposed not to have been filled, or at least elaborated on, in directions that it was not necessarily possible to predict, by the time the PhD is completed, three or five years later.

Thirsk and Clark (2017) argue that at the beginning of a research process we do not know all it is possible to know or the diverse sources that could be explored to enhance our understanding of the topic that is the object of our inquiry. I agree that it is important to be able to demonstrate a breadth and depth of understanding of the topic under review, but when there are several inter-related stages of a project and different bodies of literature that are relevant for each stage, I believe it makes sense to weave the understanding gained from an ongoing review of the literature, throughout the body of the text.

Gadamer refers to the 'art of understanding' **(GADAMER 1960 / 1989 P.164)** that, similar to Archimede's bath or Newton's apple, can arise from engagement with a singular disruptive experience (a 'eureka' moment) or from the accumulation of information from multiple sources. Hermeneutic literature reviews are expansive rather than exhaustive and are about making connections with the text that has the propensity to trigger a cascade of new ideas. For example, as a result of the literature review to identify relevant theories, the ones that stimulated my interest included the 'Broaden-and-Build theory of emotions' **(FREDERICKSON & JOINER, 2002)** and 'Attention Restoration Theory' **(KAPLAN & BERMAN, 2010)**. Further investigation exposed additional evidence that validated their relevance to health visiting perinatal mental health practice **(BRATMAN ET AL, 2015; GARLAND ET AL, 2010; GLIBERT ET AL, 2008; HAMMAN & ITZVAN, 2016; HARTIG ET AL, 2014; JENSEN & BONDE, 2018; JESTE ET AL, 2015; KEYES, 2016; MCEACHAN ET AL, 2016; MCKEE**

ET AL, 2019; WHO, 2016; WOOLHOUSE ET AL, 2016). Whilst I have acknowledged the challenges of searching for theories that might be relevant to the investigation, I can also appreciate why it is considered an important stage of the research. There are so many theories that sparked my interest and really made me think about why mothers become ill, what helps them to recover, why HVs do what they do, and what they could do differently.

For the reasons previously mentioned, I have not included a separate chapter dedicated to a literature review in this thesis, but instead have built on a hermeneutic literature review as my research has unfolded, starting with the seminal article by Holden et al (1989). I have provided details of how further 'pearl' articles are identified which then lead to the selection of other articles relevant to generating understanding about the prevalence and impact of maternal MHPs, the theories that might help to inform or explain when and how to disrupt the causal pathway of perinatal mental illness, and the views and experiences of mothers and HVs, of receiving and providing perinatal mental health care. Throughout the PhD I have been identifying, reading, storing and 'tagging' articles using Mendeley Reference Management software. I have provided details of the articles that have been included in the literature reviews presented in chapters 3, 5 and 6 and have provided the detailed criteria, PRISMA flow chart, quality appraisal and key features of the selected articles included in the more formal rapid review reported in Chapter 4.

A hermeneutic orientation also applies to the interpretation of the content of the selected articles and the way that interpretation is presented. It is inevitable that my interpretation will not necessarily be the same as anybody else's. It is not expected that the reader of a hermeneutic review will 'think' like the reviewer but that they will be able to follow their train of thought. 'Truth' can always be understood differently and one understanding is no better than any other. Grondin (1994 p.124) re-iterates a statement that Gadamer made at a conference in 1989, 'The possibility that the other person may be right is the soul of hermeneutics' (GRONDIN 1994 P.124). According to Moules (2002) validity in interpretive inquiry is enhanced by the fullness and depth to which the interpretation enhances understanding. Credibility arises from the extent to which the interpretation makes sense to the reader, even if the interpretation is not the same as their own (MOULES, 2002). It has been my intention to demonstrate how each stage of the research has its own 'story' as well as provide a believable narrative to indicate how all the constituent parts fit together. The final test is whether the proposed interpretation, in this case, represented as the EWV guide for practice, is transferable to the real world of clinical practice. The beginning of the process to explore the relevance and acceptability of the guide is illustrated by the modified technological Delphi Approach described in Chapter 8.

10.4. Revisiting the complexities of researching complex interventions

10.4.1. LVs as a complex intervention

The design of the research is guided by the assumption that LVs are a complex intervention. The complexity resides not only in intervention delivery but also in the multiple interpretations of what is meant by LVs. This has been one of the first challenges of this thesis – to define LVs.

Some individuals have queried whether LVs meet the criteria for a complex intervention. Through a hermeneutic lens it is easy to understand how different perspectives exist. Individual interpretations of the meaning of 'listening' will inevitably vary according to the fore-understandings and 'prejudices' of the interpreter. Words both limit and extend our understanding. As 'listeners,' most of the time, we assume that we have understood the meaning that the words are meant to convey. How we interpret the words that we read, or hear, also depends on our role in the encounter.

We 'connect' with what has meaning for us. A commissioner with a budget to balance may think that if LVs are only 'listening' then anybody can do it and LVs could be delivered by someone who costs less than a HV. A manager might think that if it is only 'listening' then that is what HVs do all the time, so no further training is needed. Policy-makers and other health professionals might think that 'listening' does not convey the rigour or provenance of a recognised psychological intervention so, without therapeutic value, LVs are not perceived as a cost-effective intervention. This then would call into question whether HVs can make a significant contribution to the perinatal mental health pathway of care. HVs might be concerned about what they might discover during the process of 'listening' so may be reluctant to offer LVs because they are concerned that they do not have the skills, knowledge or capacity to respond appropriately to what might be shared. Mothers might appreciate the prospect of being 'listened to' but might also be intimidated by the necessity of talking so that the HV can listen.

Although 'listening' has now been removed from the title of the intervention it remains a key component of the support provided by the HV. Renaming the intervention 'Emotional Wellbeing Visits' is considered to be more indicative of the purpose of the intervention and compatible with language in common use to describe assessment tools and information already provided to mothers. It is anticipated that a clear description of what the intervention 'is' will help to ensure a greater awareness and shared understanding of the purpose and content of a HV perinatal mental health intervention. HVs participating in the Delphi Approach thought that this would be one of the benefits of the EWV guide for practice, as it provides written evidence for everyone of not only what HVs do, but also the research underpinning the included components.

Complexity also resides in the therapeutic encounter. Unspoken words and the need for clarification of meaning seem to be a central theme. A suggestion from the research reviewed is that HVs are not explicit enough about their skillset to enable mothers to consider sharing unsettling thoughts and distressing feelings. HV non-verbal messages may convey the impression that they are unable to listen or help. Both Chapter 6 and Chapter 7 highlight the challenges that HVs encounter in terms of the constraints of time, capacity, knowledge, motivation and confidence that potentially compromise their effective engagement with families. If they are to engage, and if perinatal mental health is considered as a fundamental part of health visiting practice, then HVs need to clearly explain their perinatal mental health credentials to mothers. HVs have to be convinced, and convincing, that the support that they can provide will lead to beneficial outcomes for families. That is why the EWV guide includes reference to the need to explain the role of the HV.

Contextual factors such as workforce shortages, organisational changes and conflicting priorities seem to have exerted a pervasive negative influence on HV capacity to support mothers with MHPs (Chapter 3, Chapter 6, Chapter 7). HVs are in an impossible position. Many do not have access to appropriate training, mentorship or supervision but regularly encounter mothers, during the course of their daily work, who may be struggling with mental health issues. Whilst policy seems to be favouring other services, survey respondents have concurred that maternal mental health is an integral component of HV practice and they would like to have access to better training to enable them to provide appropriate support, and a clearer mandate about what they should be doing during the course of the support that they provide. HVs also assert that as it is not possible to separate the well-being of the mother from the well-being of the child, it is imperative that they identify and support mothers with MHPs to comply with their salutogenic focus of promoting the health and well-being of all members of the family **(COWLEY ET AL, 2015).**

The impact on the child is potentially more extensive and profound than is usually considered in reviews that focus primarily on the outcomes of cognitive developmental delay, emotional and behavioural problems in children and mental ill-health throughout adolescence that often extends into adulthood. A large proportion of Chapter 3 focussed on the impact on the child because 72% of the cost of untreated maternal mental ill-health arises from the cost of treating the adverse consequences for the child **(BAUER ET AL, 2014)**. Acknowledgement of the potential cost-savings accruing from preventing a diverse range of detrimental infant outcomes (that extend across the lifecourse) lends additional support to the economic case for preferential investment in health visitors, who potentially have the knowledge and opportunity to address the impact of maternal MHPs on parent-infant relationships and infant care **(MCDONALD ET AL, 2016)**. This is another aspect of originality manifest in this thesis. To my knowledge, the extent of, and mechanisms to explain, the impact of maternal mental ill-health on the developing foetus/child have not been brought together in this way to foster an appreciation of the multiplicity of effects.

Maternal nutrition, exposure to toxic substances and stress are the environmental influences most likely to have an impact on physiological mechanisms that determine the structure and function of the foetal brain **(ENTRINGER ET AL, 2015)**. The dose-response relationship between psychological distress in pregnancy and compromised development of the infant brain **(MEANEY, 2018)** emphasises the importance of early intervention and suggests that it might be more beneficial for the first HV antenatal contact to take place as early as possible in the antenatal period, in order to adequately address some of these issues. It is disconcerting that survey respondents (Chapter 7) have suggested that HVs in some areas of the country are no longer commissioned to offer an antenatal visit or identify and support mothers with MHPs, as if maternal mental health can be disconnected from the health, safety, growth and development of the foetus/infant **(WHO ET AL, 2018)**.

As 'speakers' we are limited in our ability to express our thoughts by the words that we have at our disposal, the words that we think are appropriate to use in a particular context, or the words that we think the listener will understand or be willing to hear. Often there are no words that adequately capture and convey experience or adequately express what we want to say. So, to really understand, we have to reflect on what is not being said as well as what is being said. This applies as much to the interpretation of what is meant by 'listening' and 'LVs' as to the challenges for mothers of finding the words to express how they feel and for HVs to find the appropriate words to frame their response.

Some of the phrases used to describe the experience of mothers capture this inability to find the right words so well, such as, 'self-silencing' 'tightrope talk' 'nameless chaos' 'struggling to find a way out' **(DAHL ET AL, 2017; MOLLARD ET AL, 2014)**. The complexity arises not only in trying to understand the meaning of what mothers are trying to tell us but also trying to understand the potential diluting or detracting effect of researchers' interpretations of maternal experience. Findings from qualitative studies may not be a true reflection of what the mothers in the studies actually meant, so may not truly represent what Sandelowski (2006) refers to as 'the voice of the voiceless'. If mothers find it difficult to express how they feel, a fundamental focus of research must be to understand how HVs can 'listen' in such a way that will be helpful and describe what they need to do to create the circumstances conducive to disclosure.

The challenges of exploring how mothers feel are reflected in a report produced by The Centre for Mental Health on perinatal mental health care which states that 'The biggest barrier to providing better support to women experiencing poor mental health in the perinatal period is low identification of need' **(KHAN, 2015. P.6.)**. Part of the reason for this may be that health professionals are not asking the right questions.

The quality standards associated with the NICE guideline for antenatal and postnatal mental health (NICE, 2014A) specify that the assessment tools should be used in the context of a general discussion about health and well-being. This principle seems to have been lost in the translation of the recommendations to practice. Survey findings from Chapter 7 suggest that this is attributable both to the way that health professional activity is measured and inadequate training of front-line practitioners. The exploration of the views of mothers in Chapter 6 reveals a dissonance between the symptoms experienced by mothers and the focus of the assessments (COATES E AL, 2015; JARRETT, 2017; LITTLEWOOD ET AL, 2018; RUSSELL, 2017). I would like to propose that over-simplification of assessment tools has devalued the foundational knowledge, time and sensitivity required to prepare mothers for the purpose, process and outcomes of assessment; undermined the importance of genuine, sincere enquiries about emotional well-being; and compromised the ability of front-line health professionals (such as midwives and health visitors) to provide consistent, competent assessment, advice and support (BEAUCHAMP, 2014; JOMEEN ET AL, 2013; HIGGINS ET AL, 2017; NOONAN ET AL, 2017 & 2018; SAMBROOK SMITH ET AL, 2019).

The raison d'être of health visiting is the assessment of need (APPLETON & COWLEY, 2008). This relates to the need for health as well as the need for healthcare. HVs undertake an assessment of family health needs for all families and thereby help to identify preventive, predisposing, precipitating and protective factors that might influence parental mental health. The similarity between the family health needs assessment and the components of the psychosocial assessment recommended in the NICE guideline (NICE, 2014A, RECOMMENDATION 1.6.1.) is not recognized or valued by policy makers, commissioners, other professionals and HVs themselves. Findings from the views of mothers and HVs in chapter 6 suggest that the HV assessment could also be improved by enhanced understanding of cultural variations in expression and interpretation of symptoms, and the identification of resilience factors that contribute to emotional, psychological and social well-being (EDGE & LEMETYINEN, 2019; JESTE ET AL, 2015: FRANKEN ET AL, 2018).

As part of differentiating the role of the HV from the role of mental health professionals, the EWV guide for practice alludes to an HV assessment of maternal mental health commensurate with their professional remit. The purpose of HV assessment is not to see if mothers have symptoms that signify a mental illness, but to identify vulnerability factors that might increase the likelihood of mothers experiencing mental ill-health; bolster resilience factors likely to enhance emotional wellbeing; assess maternal mental state; explore how mothers are feeling and coping; and then offer support to address any of the identified issues; with the ultimate ambition of promoting maternal and family emotional wellbeing. The EWV guide for practice therefore contains specific sections on psychosocial assessment and assessment that describe, in detail, the comprehensive nature and relevance of a HV assessment.

The transition to motherhood involves fluctuations in physiology, appearance, relationships, responsibilities, needs, priorities and identity (WADEPHUL ET AL, 2019). These dynamic changes require multiple adaptive capacities that can be enhanced or compromised by characteristics of the maternal personal, social and physical environment. Theories and research (Chapter 4, Chapter 5) indicate that perceived and actual support help mothers to adapt to these changes thereby improving psychological well-being and quality of life (MILGROM ET AL, 2019; NEGRON ET AL, 2013). HVs have a role in both providing informational and appraisal support and facilitating access to social, emotional and instrumental support from others (BROOK, 2015; GINJA ET AL, 2018; LAW ET AL, 2018; MILGROM ET AL, 2019 P.1). The focus of the fifth visit in the EWV guide for practice is 'managing relationships and building support networks,' although any of the proposed content in any of the scripted visits can be used at any time, as deemed appropriate by the HV.

In order to develop an effective therapeutic alliance, health professionals need to be able to establish a trusting relationship with mothers **(DENNIS, 2005; HADFIELD ET AL, 2019; NEWMAN ET AL, 2019)**. Establishing relationships with families is a fundamental component of health visiting practice **(COWLEY ET AL, 2015)**. It is clear from Chapter 6 that mothers would like to have contact with a health professional who is willing to listen and able to help. Sensitive assessment provided by a genuine, caring, non-judgemental professional can help to raise self-awareness; promote self-appraisal; dissipate anxieties; increase motivation for self-management or mobilization of sources of support; and identify meaningful markers of recovery **(COWLEY ET AL, 2015; DARWIN ET AL, 2013)**. Mothers want someone to talk to about the many aspects of their lives that impact on their emotional wellbeing. These include breastfeeding, infant care, self-care, relationships, housing, finances and loneliness (Chapter 6). The purpose of the HV comprehensive assessment of maternal mental health specified in the EWV guide is therefore to explore all these things and, if any of them are compromising maternal emotional wellbeing, and the mother would like to spend time talking about them, to offer the opportunity to talk about them during the course of a EWV.

The purpose of LVs, according to the definition in the NICE guideline is, 'to help mothers to gain a better understanding of their circumstances and themselves so that they can find the solutions that are right for them' **(NCCMH, 2014 P. 213)**. The vagueness of the definition contributes to the challenges of determining which mothers should be eligible for LVs or what the intervention should entail, evidenced by findings from the survey (Chapter 7) and the views and experiences of mothers and HVs (Chapter 6). The statement implies that LVs should respond to any aspect of maternal circumstances that affect maternal mental health. It is not clear how or why this definition was adapted to proscribe eligibility for LVs based on circumstances, and, instead, make eligibility dependent on the presence of a certain number of symptoms ascertained by a score on an assessment tool, such as the EPDS.

Identification of the components of effective perinatal mental health interventions (Chapter 4) revealed a number of frequently occurring components that have been included in the HV guide for practice. The core tenet of a transdiagnostic model is that treatments are not disorder-specific but target shared mechanisms contributing to the development or maintence of symptoms of one or more diagnostic categories **(SINGLA ET AL, 2017)**.

The most frequently occurring components identified through the use of the modified distillation and matching process (mood management, psychoeducation, problem-solving, managing relationships, activating support networks, maternal and infant well-being/care) are included in the guide for practice. Several of the components were derived from interventions guided by, or allied to, CBT, such as structured problem-solving, behavioural activation or cognitive restructuring. These techniques are often suggested as useful adjuncts to a HV perinatal mental health intervention, although the 70% consensus threshold was only breached for structured problem-solving in the Delphi study (Chapter 8). Some of the perceived discrepancies in what HVs think should be included in HV interventions may arise from differential understanding of the meaning of the terms that are used. HVs may not subscribe to the use of behavioural activation as a technique but may encourage depressed mothers to resume or plan pleasurable activities (that could be construed as behavioural activation). This resonates with research from Australia that expounds the relevance of an hour a week of 'time for self' in reducing the likelihood of experiencing PND in the first six months postpartum. **(WOOLHOUSE ET AL, 2015)**. A simplified version of behavioural activation (BA) is included in the HV guide for practice as it serves the dual purpose of fostering engagement in valued activities and securing 'time for self' for mothers. The remaining commonly

occurring components in effective interventions identified using the DMM (Chapter 4) are also included in the EWV guide for practice.

Exploration of the theories that might inform, predict or explain the causes, symptoms, treatments and outcomes of perinatal MHPs generated enhanced understanding about the perceptions and actions of individuals providing and receiving care and inspired a cornucopia of suggestions that could be incorporated into an updated HV intervention. These include a recognition of the concept of well-being as distinct from mental ill-health and the need to consider factors and interventions conducive to 'flourishing' in the perinatal period, as well as those that lead to the relief of symptoms of MHPs **(JOMEEN & MARTIN, 2018)**. There is evidence of effectiveness of positive psychology interventions in reducing symptoms of depression **(BOLIER ET AL, 2009; SIN & LYUBOMIRSKY, 2009)**. Hitherto, these have not been routinely used in perinatal mental health interventions so their inclusion in the proposed guide for practice represents an innovation in intervention delivery.

Lifestyle factors such as nutrition, exercise and immersive experiences in nature or creative expression potentially have an impact on maternal emotional well-being and may be more acceptable to mothers than formal psychological therapies. The evidence underpinning the benefits of nutrition, exercise and stress-busting strategies for improved mental health are included in the updated guide for practice.

In accordance with the view that 'one size does not fit all' and mothers want to be able to choose from a range of possible components that might help them to feel better, components extracted from the interventions identified in the rapid review of effective interventions (Chapter 4), the review of relevant theories and the views and experiences of mothers and HVs (Chapters 5,6 & 7) are included in the EWV guide for practice. Multidimensional opportunities for the prevention and treatment of maternal MHPs, as well as the promotion of the well-being of the next generation, are compatible with the public health role of HVs. A range of options also accommodates the NHS guiding principle of shared decision-making and embodies the shift of focus from 'what is the matter with you?' to 'what matters to you?' **(NHS ENGLAND, 2017 P.3)**.

10.4.2. Perinatal mental health care as a complex adaptive system

The focus of this study was on the role of the HV. Explicating the role of the HV is not enough. The HV is part of a complex adaptive system (CAS) of people, processes and things that interact and connect with each other in unpredictable and unplanned ways to adapt to prevailing circumstances **(GREENHALGH & PAPOUTSI, 2018)**. As circumstances change, the elements of the system seek new ways of adaptation. CASs are constantly moving between a state of equilibrium and chaos. Systems that are unable to adapt to the demands of their environment gradually move to a state of chaos and eventually cease to exist **(GREENHALGH & PAPOUTSI, 2018)**. Within the healthcare arena there are systems within systems so changes in one system can have repercussions for an interacting system. For example, the NCT campaign to secure funding for GP's to have extra time to assess maternal mental health at 6 weeks post-birth may have a knock-on effect of reducing funding for the HV maternal mental health assessment scheduled to take place at the same time. With the increased focus on facilitated self-help as the recommended intervention **(NICE, 2014A)** for mothers with MHPs, funding has already been transferred to IAPT services, without a clear understanding of whether mothers are likely to find this acceptable or whether IAPT practitioners have the necessary knowledge and skills to respond to the mental health needs of perinatal mothers.

An effective perinatal mental health pathway of care relies on each professional or service understanding their role in the context of what other professionals or services can offer. There will be some overlap but there also needs to be acknowledgement that each professional group has a unique skillset and role in perinatal and infant mental health systems of care. The contributions of the different professions need to be clearly articulated to ensure the optimal provision of integrated care, rather than expect all professions to do the same thing, or single out one profession to meet the needs of all families. There is a danger that generic responsibilities allocated to everyone end up with nobody doing anything well, with the risk that mothers, their partners and their infants continue to fall through the gaps **(EASTER ET AL.2019; KHAN, 2015; MYORS ET AL, 2015; ROTHERA & OATES, 2011; SILVERWOOD ET AL, 2019)**. Each professional needs to know how they fit into the pathway of care, what every other professional can offer mothers and their families, and how mothers' transition from one level of care to the next.

Health professionals not only need to share information with each other but also need to be much better at letting families know exactly what support they can offer and who else can help if the HV is unable to meet the family's needs, or the mother would prefer to see someone else. Shared learning and joint participation in quality improvement initiatives is likely to enhance provision of optimal care. Recognition of the need for mental health specialists to provide consultation and supervision to less experienced clinicians, such as HVs, is likely to reduce demand for more specialist services as well as improve the appropriateness of referrals.

Despite a national campaign led by the Maternal Mental Health Alliance to make maternal mental health everybody's business, there appears to be a reluctance to acknowledge and safeguard the role of the HV in the prevention, early identification and prompt treatment of perinatal MHPs. This seems to be at odds with the evidence demonstrating the impossibility of providing sufficient mental health specialists to meet the increasing number of individuals experiencing MHPs **(KAZDIN & BLASE, 2011)**; the proven effectiveness of 'task-shifting' the responsibility of providing care to non-mental health specialists **(RAHMAN ET AL, 2013)**; the improved outcomes achieved by interventions delivered by HVs compared to identical interventions delivered by mental health specialists **(COOPER ET AL, 2003; MILGROM ET AL, 2011)**; the need to consider the social determinants of mental health **(WHO, 2014)**; a renewed emphasis on prevention **(NHS ENGLAND, 2014B)**; and maternal preferences for home-based support provided by a familiar, kind, compassionate HV or MW who is well-informed about mental health, childbirth, parenting and self-care **(BHAT ET AL, 2018; DAS, 2019; HANSOTTE ET AL, 2017; LAW ET AL, 2018, O'MAHEN ET AL, 2012; RUSSELL, 2017; SOCIAL MOBILITY AND CHILD POVERTY COMMISSION 2016)**. It is hoped that a clearer explanation of the comprehensive nature of HV assessment, intervention and prevention will enable HVs to raise their profile in perinatal mental health; campaign for increased investment in the HV workforce; integrate effectively with other professionals to ensure seamless provision of care; and demonstrate their ability to improve outcomes for families. No sustainable change will happen unless there is a collective commitment to ensuring that HVs have the knowledge, capacity and skills to provide the support that evidence suggests will make a difference to the present and future mental health of mothers and their children.

10.4.3. Critical reflection of the research process

The enhanced version of the MRC guidance for developing and evaluating complex interventions provided a useful framework for this PhD study **(BLEIJENBERG ET AL, 2018)**. A systematic approach to an exploration of current service provision; the purpose, mechanisms of action and effectiveness of the intervention (LVs); and the factors influencing how the intervention has evolved and is perceived by

providers and recipients have generated greater insight into what can be done to improve HV perinatal assessment, intervention and outcomes. However, the research process has required multiple and extensive reviews of the literature as well as collection and analysis of diverse sources of data. All of these stages have been time-consuming and subject to a range of biases that have the potential to compromise the validity of the outcome. The amount of work involved in each stage of the research process has felt overwhelming at times, mostly because of the volume of relevant literature that needed to be considered, although, in my view, this has been a worthwhile exploration.

However, although care has been taken to fully record and explain the decisions taken in this research **(MOULES, 2002)** and the research process has followed a sequence of recommended stages **(BLEIJENBERG ET AL, 2018)** with each stage following the guidance for the conduct and reporting of the particular method (the survey and the Delphi Approach), or using a recognised framework for standardising the presentation of the findings (the TDF or the TIDieR checklist), it has all taken too long. In a society that expects instant access and immediate results, there is constant pressure to do more with less, to drive engagement and secure results faster and more effectively. Organisations and professionals need to be able to adapt rapidly to the pace of change. They will not want to wait five years for an innovative idea to come to fruition. We need to explore new ways of developing, testing, evaluating and upscaling promising interventions. I propose that researchers in healthcare would benefit from adopting some of the 'Agile' strategies used by successful businesses.

This PhD study has been a collaborative venture involving contact with over 1600 HVs. This is less than 20% of the HV workforce and therefore the views expressed by HVs responding to the survey or participating in the Delphi approach may not be representative of the target population. Triangulation of the findings from the survey with the synthesis of evidence from other studies lends more credence to the assumptions made and conclusions reached. Co-ordination with other researchers investigating the perinatal mental health practice of PHNs **(CUNNINGHAM & GALLOWAY, 2018; HIGGINS ET AL, 2017, 2018; JOMEEN ET AL, 2013; NOONAN ET AL, 2017, 2019)** might have improved the comparability and generalisability of the findings. It would also have been useful to convene a steering group at the beginning of the study to secure input from key stakeholders, including mothers.

Whilst other researchers have conducted surveys of HV views and practice, there is very little research exploring how to move forward with new ideas that could inform new ways of working. The preferential focus both in terms of supporting families and understanding practice seems to be on assessment. Just as a respondent in the HV survey lamented the fact that mothers seem to be assessed and assessed again but don't seem to be eligible for treatment, research seems to be focussed on measuring the scale and impact of the problem rather than what needs to happen to improve interventions and outcomes. Identifying the theories that might be relevant, although a daunting and challenging exercise was also stimulating and intriguing as it introduced a body of literature that otherwise might not have been discovered. Many of the theories have provided the catalyst for exploring the evidence that underpins some of the components included in the guide for practice.

From the evidence synthesis of the views of women and the views of HVs, it would appear that clinicians attribute value to the techniques that they feel they need to learn to enhance their understanding and practice, whereas the mothers represented in this study (Chapter 6) want someone to talk to who might be able to suggest some simple easy-to-do strategies that will help them to feel better. For this reason, the EWV guide risks being dismissed by practitioners seeking a more sophisticated approach, although its

simplicity and intended compatibility with existing HV aspirations and practice will hopefully contribute to its widespread use and impact.

Blase et al (2018 p.3.) maintain that usable innovations must be 'teachable, learnable, do-able , assessable and scalable in practice.' The drivers of successful implementation are competent practitioners, motivated leaders and supportive organisations **(BLASÉ ET AL, 2018)**. Although training is important, training on its own (a 'train and hope' strategy) is not sufficient to change practice. Adoption of the new guide for practice requires active and continuing engagement of practitioners, managers, commissioners and policy makers to monitor use, acceptability, dissemination, adaptations and outcomes.

With regard to the content of the EWV intervention, I am re-assured that I have been 'on the right track', by a number of articles published in the 'World Psychiatry' journal post-completion of my thesis. For example, Glover (2020) draws attention to the benefits for the unborn child of supporting antenatal mothers who do not have a diagnosable mental disorder but are experiencing stress, or an increase of 'daily hassles,' during pregnancy. Glover (2020) proposes that it might be advantageous if antenatal assessments of maternal mental health included consideration of a broad range of vulnerability factors including stressful life events, adverse childhood experiences, the quality of the relationship with the partner and socioeconomic circumstances. The implication was that these factors are not included in routine antenatal assessment. They are included in the integrated assessment and intervention framework that provides the basis of the EWV guide for practice. In an article in the same series, there is also reference to things that are not being done that should be done (such as enquiries about self-harm) **(HOWARD & KHALIFEH, 2020)**. Again, these are included in the integrated assessment and intervention framework. A further article by Alderdice (2020) emphasises the benefits of focussing on 'flourishing' in the perinatal period and advocates including wellbeing approaches in pro-active interventions to promote positive perinatal mental health. The EWV guide for practice emulates this ambition.

A meta-meta-analysis identified a number of evidence-based, effective, self-guided interventions, that could be recommended for socially isolated individuals to alleviate anxieties, stress and worries; decrease negative mood and depressive symptoms; and increase positive psychological functioning and subjective well-being **(FISCHER ET AL, 2020)**. The recommended interventions include those based on cognitive behavioral therapy (emotion recognition and management, behavioural activation), mindfulness, and acceptance-based activities, selected positive psychology activities (positive writing, three good things and gratitude journal), physical exercise, nutrition, sleep hygiene and music as useful first-line mental health interventions. Many of these ideas and strategies have been included in the draft EWV guide for practice. These articles published in world-renowned, peer-reviewed journals suggesting that the recommended aspects of practice that should be done but aren't being done, imply that the evidence presented in this thesis represents an original contribution to the body of knowledge. If not original, it is, at least a kaleidoscope of ideas compatible with the thinking of current, innovative, trailblazing, perinatal mental health researchers.

10.5. Conclusions

The conclusion of this study is that investigating any intervention designed to treat symptoms of mental ill-health is fraught with complexity. Exploring interventions that might be appropriate for mothers experiencing perinatal MHPs accentuates this complexity as symptoms indicating psychological distress in the perinatal period are difficult to differentiate from those that arise from the repercussions of childbirth and the transition to parenthood. This study has demonstrated that complexity resides in multiple aspects of assessment and intervention. These include the range, severity and impact of symptoms; the number and flexibility of components; the difficulty in defining the active ingredients; the range of skills and actions required by HVs and mothers; the challenges of identifying the features of relationships or the combination of actions that confer synergistic benefits; the variety of outcomes; and the contextual factors that influence implementation **(CRAIG ET AL, 2008; MOORE ET AL, 2014; PFADENHAUER ET AL, 2013).**

The role of the HV in preventing, identifying and treating maternal MHPs has been explored in detail and the conclusion reached that identifying and supporting mothers with MHPs as well as promoting maternal emotional wellbeing is a fundamental component of HV practice. An examination of LVs has revealed some of the challenges of definition and delivery. The primary ambition to 'move on' from LVs has been achieved. Survey respondents were asked if they thought that the HV intervention should be called LVs, facilitated self-help, or something else. Delphi delegates were also invited to consider alternative suggestions if they were not happy with these labels. The consensus was that the new interventio nshould be called 'emotional well-being visits' as this is compatible with the Tommy's 'emotional well-being plan' given to all mothers during pregnancy.

A comprehensive approach to exposing the factors that affect HV practice and the potential components of effective, acceptable and feasible interventions have culminated in the development of a prototype guide for practice. The guide represents a novel way of presenting how HVs can assess maternal strengths, resilience, vulnerability, need and risk and offers an evidence-informed intervention composed of essential and flexible components that can be tailored to the symptoms, needs, preferences and circumstances of mothers. The EWV guide represents a departure from previous LV manuals **(HOLDEN ET AL, 1989; COOPER ET AL, 2003; MURRAY ET AL, 2003; MORRELL ET AL, 2009)** as it is written in the form of a script and includes a comprehensive range of therapeutic options as well as the evidence justifying their inclusion. The advocated approach supports the principles of integrative mental health care by affirming the importance of the therapeutic alliance, embracing a holistic, goal-oriented perspective and using a diverse range of evidence-based interventions to achieve 'optimal health and healing.' **(SARRIS ET AL, 2014 P.11).** As the survey of HVs indicated limited use of outcome measures, and the NICE guideline **(NICE, 2014A)** recommends their use, the guide advocates the use of additional assessment tools to promote social connection, explore positive as well as negative emotions, and monitor weekly progress and final outcomes.

Just as mothers who are stressed are more likely to find unstructured (compared to structured) sessions with their infant more challenging **(PSYCHOGIOU & PARRY, 2014)**, it is hypothesised that stressed HVs will find structured interventions easier to deliver. They are also likely to be more acceptable to mothers and foster sustained engagement with the intervention. HVs are more likely to offer intervention components that are compatible with their personal beliefs and professional ethos, are easy to explain and have the potential to be helpful **(LASKA ET AL, 2013).** Responses from Delphi delegates indicate their appreciation of this novel approach. As there is nothing like it that currently exists, the updated guide for practice, and the way that it has been developed, represents an original contribution to the body of knowledge.

10.6. The future

This PhD study signifies the beginning rather than the end of the process. Cathain et al (2019) have identified the key principles and actions involved in the development or re-design of complex interventions. These include 'seeing intervention development as a dynamic iterative process, involving stakeholders, reviewing published research evidence, drawing on existing theories, articulating programme theory, undertaking primary data collection, understanding context, paying attention to future implementation in the real world and designing and refining an intervention using iterative cycles of development with stakeholder input throughout' **(O'CATHAIN ET AL, 2019 P.1)**. Whilst the last action began in the last stage of the research (Chapter 8), further iterative cycles have subsequently taken place and will continue in the foreseeable future.

Unfortunately, the progress of a quality improvement initiative involving a collaboration between HVs, the medical records department and the quality improvement team in an NHS Trust has been hampered by the restrictions imposed by the pandemic. A further two cohorts of HVs were involved in a pilot to test the use of the guide in practice and explore how the training can be improved to facilitate the cascade of training to other HVs. Additional resources have been developed to aid delivery such as a shortened guide, aide memoires for each visit and each strategy / technique and tools to facilitate exploration of positive and negative emotions, availability of support and to monitor weekly progress. Further iterative cycles of implementation, feedback and improvement are planned. Mechanisms for assessing competence and treatment adherence will also be explored. Articulating a programme theory of change has been considered but not yet visualised. This will be developed following further iterations of the guide and feedback from HVs. The views of other stakeholders, especially mothers, need to be explored.

It will be a challenge to incorporate all the elements in the EWV guide into training programmes when HVs are unlikely to be released for more than 2 days to engage in learning opportunities (personal communication from representative from iHV) and when consolidation of knowledge and skills in practice relies on the availability and coaching skills of a more knowledgeable other. If current practice is to change, there needs to be a much greater commitment to the delivery of high quality, evidence-based, blended learning opportunities and a recognition of the time required to learn, apply and embed skills in practice. HVs must have access to regular supervision and specialist mental health expertise. Processes and measures need to be implemented to assess competence, confidence, acceptability and effectiveness **(SINGLA ET AL, 2017)**. Alternative outcome measures need to be developed that are not solely focussed on reduction of symptoms of anxiety and depression.

I am also aware of the resistance to change that comes with the challenge of having to learn something new when you are feeling stressed and overwhelmed, so I am not sure what the response of HVs will be to a re-designed intervention. Margaret Hefferman (2012) in her book *'Willful Blindness'* suggests that we are wilfully blind to things we don't want to see. Our brains are wired to ignore evidence that contradicts our beliefs and we are capable of performing cognitive acrobatics to rationalise away the contradictions. It is easier to carry on doing what we have always done and ignore information that requires us to think or act differently. However, regardless of what happens next, I consider the translation of my research into practice as a positive end-result, but also hope that it will be the catalyst for future development of EWVs, the training that is required to deliver them and the development of systems for recording process and outcomes.

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Appendix 1 Table 1 Checklist of key implementation processes – relevant to Chapter 4

TABLE 1. CHECKLIST OF KEY IMPLEMENTATION PROCESSES FOR PSYCHOLOGICAL TREATMENTS APPLIED TO EFFECTIVE INTERVENTIONS IDENTIFIED IN LITERATURE REVIEW. (PART 1 OF 7)

STUDIES	COOPER ET AL, 2009	MORRELL ET AL, 2009	ROMAN ET AL, 2009
WHERE?	**KHAYELITSHA, SOUTH AFRICA**	**TRENT REGION OF ENGLAND**	**KENT COUNTY, MICHIGAN, U.S.A.**
TREATMENT SETTING			
Rationale for setting	Mother-infant interactions are adversely affected by socioeconomic circumstances and maternal mood.	Growing concern about the number of women and their families affected by MHPs and the need to explore different ways of identifying and helping them.	Low-income pregnant women often live in stressful circumstances. Almost half of these women screen positive for depression. Available treatments are not always successful or do not have a sustainable impact. It may be because insufficient attention is given to the stressors precipitating or maintaining depressive symptoms. The perinatal period provides a unique opportunity to identify and provide support as mothers have increased contact with health professionals.
Barriers and facilitators related to setting	High levels of unemployment, poverty, overcrowding and intrusive parenting in Khayelitsha. Mobile population. High rates of postnatal depression. Previous projects recruiting and training local mothers to improve maternal and infant health had been successful.	Large population. Cluster randomization meant that many organisations and professionals were involved so the trial took some time to set up.	Medicaid provide matched funds for enhanced perinatal care. Many women are not accessing the care they are entitled to. Symptoms of mental ill health may also prevent women from engaging with the home visiting service. Community Health Workers can help mothers to overcome language and cultural barriers that prevent them from engaging with health professionals.
WHO?			
Who delivered the treatment?	Lay community workers	Health visitors	Nurse / Community Health Worker team (CHW)
How were they selected?	4 mothers selected with help from the local community council.	Invited to participate in the research via line managers who were recruited via local research collaboratives.	From local community (CHW) Or employed in existing health service (nurse)
Rationale for selection	Local mothers	All HVs in the Trent region	High School Diploma

TABLE 1. PART 1 CONTINUED

STUDIES	COOPER ET AL, 2009	MORRELL ET AL, 2009	ROMAN ET AL, 2009
Demographics (age, gender, experience)	No specialist qualifications	HV qualification.	Some CHW's had prior experience of working in health or community settings.
Compensation	Not specified	Incorporated into HV role	Not specified
Certification process	Not specified	Not specified	Certificated core training programmed sponsored by CHW training collaborative and local college.
Is there access to an expert?	Yes	Yes	Yes
What is the role of the expert?	Providing consultation and supervision.	Weekly review and support from research coordinator. Monthly reflective practice sessions with trainer (x4).	Nurse is the expert for the CHW - Case management, crisis intervention, liaison with other services, consultation, monitoring and supervision.
WHAT			
Theoretical orientation	Based on attachment theory, the purpose of the intervention was to help mothers to recognise and respond to the unique strengths and capabilities of their infant. The Neonatal Behavioural Assessment Scale was used during home visits to help mothers tune into their baby's needs.	Three arms of the trial. In one arm, HVs delivered an intervention based on non-directive counseling (NDC). In the other arm, the intervention was based on cognitive behavioural therapy (CBT). Third arm – control group.	Ecological stress theoretical framework used to guide the intervention (Pearlin & Schooler, 1978) This theory posits that stressful environments affect health and well-being though multiple pathways culminating in biological and physical consequences. Having to continually cope with stress erodes maternal psychosocial protective resources and undermines capacity to utilize sources of help.
Treatment class	Mother-infant interaction guidance; counseling	Talking therapies	Counseling

TABLE 1. PART 1 CONTINUED

STUDIES	COOPER ET AL, 2009	MORRELL ET AL, 2009	ROMAN ET AL, 2009
TREATMENT COMPONENTS - ELEMENTS			
Non-specific	Establishing trusting, supportive relationship; empathy; warmth; non-judgemental attitude; active' listening; empathic responding.	Establishing trusting relationship, positive regard, empathy; 'active' listening.	Establishing trusting relationship; empowerment; unconditional positive regard; intensive supportive relationship.
Specific	Psychoeducation; psychosocial assessment; assessment of maternal well-being; promoting maternal self-care; assessing maternal mood; behavioural activation; problem solving; activating social networks.	Cognitive Behavioural Approach Three specific techniques taught: behavioural activation; cognitive restructuring; problem-solving. Person-centred Approach based on the premise that an individual can find their own solutions if they have an opportunity to talk about how they feel with an empathic, non-judgemental other.	Problem-solving; goal-setting; managing relationships and accessing community resources; persistent efforts to engage and retain women in the programme.
In-session techniques	Agenda setting; motivational interviewing; anticipatory guidance about baby's needs and development; promoting sensitive responses to baby cues; teaching techniques to manage crying and help the baby settle and sleep; monitoring child development; supporting couple relationships; giving praise; preparing for endings.	Agenda setting; PLUS in CBA intervention: structured problem solving, cognitive restructuring, behavioural activation.	Promoting positive health behaviours, developing self-awareness of stressors; empowerment strategies to give mothers the confidence to identify their needs, explore solutions and develop practical skills.
Description of adaptations for specific context or target group	The intervention was based on an intervention delivered by health visitors in the UK, which in turn was based on the book 'The Social Baby'. Adapted for this project by incorporating the principles of WHO document 'Improving the Psychosocial Development of Children.'	The CBA and PCA were brief interventions guided by the principles of NDC and CBT and the British Association of Counselling ethical framework for good practice. The BCA was based on the Five Areas Approach (Williams et al, 2008).	Adapted from 'Building Strong Families' programme. (Michigan State University).

TABLE 1. PART 1 CONTINUED

STUDIES	COOPER ET AL, 2009	MORRELL ET AL, 2009	ROMAN ET AL, 2009
HOW - TRAINING			
Who conducted the training?	Not specified	Clinical specialists who were also experienced trainers in each of the two approaches.	CHW training collaborative
How long was the training? (hours)	Specific number of hours/ days not specified. Delivered over 4 months	8 days	10 sessions, followed by monthly training sessions.
What was the format of the training?	Not specified	Face-to-face using a mixture of formats including didactic teaching, discussion and role-play.	Not specified
What were the procedures for assessing competence?	Not specified	Adherence rating scale developed to assess HV fidelity to intervention. Audiotaping of sessions.	Not specified
SUPERVISION			
Who conducted supervision?	Clinical Psychologist	Trainers provided monthly reflective sessions for 4 months PLUS peer-to-peer supervision.	Not specified
What was the format of the supervision?	Weekly group supervision	See above	Not specified
What supervision methods were used?	Not specified	Not specified	Not specified
TREATMENT CHARACTERISTICS			
How was treatment delivered? (remote, group, individual)	In participants' homes. Individual.	In participants' homes. Individual.	In participants' homes. Individual.
How long was treatment? (intended vs actual)	Mothers visited twice antenatally, weekly for the first 8 weeks postpartum, fortnightly for another 4 visits and then monthly for 2 months.	Mothers identified with EPDS 12+at 8 weeks postpartum were offered up to 8 weekly sessions	Mothers identified in the first trimester offered fortnightly visits during pregnancy, weekly visits during first 8 weeks postpartum, fortnightly until 6 months and fortnightly or monthly until 12 months (as negotiated between mother and CHW).

TABLE 1. PART 1 CONTINUED

STUDIES	COOPER ET AL, 2009	MORRELL ET AL, 2009	ROMAN ET AL, 2009
How many sessions? (intended vs actual, min and max; booster sessions).	16 sessions	Up to 8	Max 50 Actual – received an average of 24.4 contacts
How long were the sessions (intended vs actual; min and max).	I hour	1 hour	Not specified
Were sessions delivered in a temporal sequence?	Yes	No	Not specified
Was the treatment manualised? (if so, provide URL).	Yes - http://www.reading.ac.uk/web/files/cls/Khayelitsha_manual.pdf	Yes	Yes
How was the quality of therapy assessed?	Not specified	Agnew Relationship measure completed by both participant and HV after each intervention session	Not specified
What is the no or percentage of individuals who completed the entire treatment package?	76% (342/449) of the recruited women were still engaged by the final assessment at 18 months postpartum.	48% of eligible women were offered the intervention (197/404), 60% of those offered the intervention accepted it (121/197). 31% of all eligible women received at least one psychological intervention session. The average number of sessions for women in the intervention group was 4.1.	86% of mothers were retained in the trial up to 15 months postpartum. There is insufficient information about the amount of input mothers in either the intervention or the control group received.

TABLE 1. CHECKLIST OF KEY IMPLEMENTATION PROCESSES FOR PSYCHOLOGICAL TREATMENTS (SINGLA ET AL, 2017). (PART 2 OF 7)

STUDIES	GLAVIN ET AL, 2010	MILGROM ET AL, 2011A	MILGROM ET AL, 2011B
WHERE?	**2 MUNICIPALITIES, NORWAY**	**MELBOURNE, AUSTRALIA**	
TREATMENT SETTING			
Rationale for setting	High prevalence and serious consequences of postnatal depression (PND)	Approximately 9% of pregnant women experience depression. Evidence is accumulating regarding the risk of adverse outcomes befalling the mother and her family.	Universal assessment of postnatal depression and access to prompt treatment is considered best practice in many countries. The majority of woman identified have mild to moderate mental health problems and can usually be managed in primary care.
Barriers and facilitators related to setting	Often undiagnosed and untreated. Important clinical issue for primary care services. All women have at least 10 contacts with Public Health Nurses (PHNs) during their first postnatal year. Early detection has the potential to prevent long-term consequences.	Although prevention and early intervention are desirable existing interventions have had variable success, partly because of poor recovery and high attrition rates.	Treatment in primary care depends on who is available to provide it and whether they have the requisite skills to deliver an effective treatment. Mothers generally prefer psychological to pharmacological treatments. There are often long waiting lists to see a mental health specialist. Referrals to treatment and uptake of offered treatment is generally low.
WHO?			
Who delivered the treatment?	Public Health Nurses (PHNs)	Essentially self-help treatment with weekly remote support from psychologists / trainee psychologists.	Maternal and Child Health Nurses and psychologists who agreed to participate in the study.
How were they selected?	No selection: worked in the study sites.	Not specified	No selection: worked in the study sites.
Rationale for selection	As above. At Least 1year post registration work as a nurse + 1 year's post-graduate education in public health and preventive services for infants, children, adolescents and their families.	Not specified	Nurses/ psychologists / trainee psychologist already employed in the health service.
Demographics (age, gender, experience)	The 26 PHNs working in the intervention group were aged 33 – 62and had been working as PHNs from 1 – 24 years.	Not specified	Not specified

TABLE 1. PART 2 CONTINUED

STUDIES	GLAVIN ET AL, 2010	MILGROM ET AL, 2011A	MILGROM ET AL, 2011B
Compensation	Integrated into usual role	Not specified	Usual pay
Certification process	Not specified	Not specified	Not specified
Is there access to an expert?	Not specified	Yes	Not specified
What is the role of the expert?	Not specified	Senior clinicians supervised postgraduate trainees.	Not specified
WHAT?			
Theoretical orientation	Non-directive counseling (Rogers, 1951)	Cognitive Behavioural Therapy	Counseling Cognitive Behavioural Therapy
Treatment class	Talking therapies	Talking therapies	Talking therapies
TREATMENT COMPONENTS - ELEMENTS			
Non-specific	Respect for mother; consideration; Self-awareness; self-respect; being open; establishing a positive, trusting relationship; 'Active' listening; empathic communication; warmth.	Not specified	Not specified.
Specific	Psychosocial assessment; assessment of maternal mental state; developing shared understanding; exploring preferences and needs; facilitating generation of solutions.	The intervention is based on a self-help workbook 'Towards parenthood.' The intervention uses cognitive behavioural strategies to target modifiable risk factors such as existing mental health problems; perceptions of stressful life events; symptoms of anxiety and depression; traumatic or unsatisfactory childhood experiences; partner relationships and social networks; maternal representations and attributions about the baby; unrealistic expectations of parenting; limited knowledge / awareness about infant capabilities and needs; compromised self-care; inability to cope.	The intervention was enhanced GP management on it's own (the control group) or enhanced GP management plus adjunctive counseling from either a public health nurse or a psychologist/trainee Elements included: psychoeducation; problem solving; goal setting; behavioural activation; relaxation; basic cognitive techniques; Supporting partner and infant relationships; activating social networks; collaborative care.

TABLE 1. PART 2 CONTINUED

STUDIES	GLAVIN ET AL, 2010	MILGROM ET AL, 2011A	MILGROM ET AL, 2011B
Compensation	Integrated into usual role	Not specified	Usual pay
Certification process	Not specified	Not specified	Not specified
Is there access to an expert?	Not specified	Yes	Not specified
What is the role of the expert?	Not specified	Senior clinicians supervised postgraduate trainees.	Not specified
Theoretical orientation	Non-directive counseling (Rogers, 1951)	Cognitive Behavioural Therapy	Counseling Cognitive Behavioural Therapy
Treatment class	Talking therapies	Talking therapies	Talking therapies
Non-specific	Respect for mother; consideration; Self-awareness; self-respect; being open; establishing a positive, trusting relationship; 'Active' listening; empathic communication; warmth.	Not specified	Not specified
Specific	Psychosocial assessment; assessment of maternal mental state; developing shared understanding; exploring preferences and needs; facilitating generation of solutions.	The intervention is based on a self-help workbook 'Towards parenthood.' The intervention uses cognitive behavioural strategies to target modifiable risk factors such as existing mental health problems; perceptions of stressful life events; symptoms of anxiety and depression; traumatic or unsatisfactory childhood experiences; partner relationships and social networks; maternal representations and attributions about the baby; unrealistic expectations of parenting; limited knowledge / awareness about infant capabilities and needs; compromised self-care; inability to cope.	The intervention was enhanced GP management on it's own (the control group) or enhanced GP management plus adjunctive counseling from either a public health nurse or a psychologist / trainee Elements included: psychoeducation; problem solving; goal setting; behavioural activation; relaxation; basic cognitive techniques; Supporting partner and infant relationships; activating social networks; collaborative care.

TABLE 1. PART 2 CONTINUED

STUDIES	GLAVIN ET AL, 2010	MILGROM ET AL, 2011A	MILGROM ET AL, 2011B
In-session techniques.	Not specified	Mothers were encouraged to read a unit in the workbook every week and try out any suggested activities. Pre-arranged telephone sessions with the psychologist/ trainee provided an opportunity to discuss the content of each unit and explore any issues raised.	Not specified
Description of adaptations for specific context or target group	Not specified	A previous version of the workbook used in this study was updated following a feasibility trial.	Intervention based on the 'Overcoming Postnatal Depression' manual (produced by the Parent Infant Research Institute, Melbourne).
HOW - TRAINING			
Who conducted the training?	Not specified	Not specified	Senior Psychologist
How long was the training? (hours).	5 days	Not specified	0.5 days
What was the format of the training?	Not specified	Not specified	Not specified
What were the procedures for assessing competence?	Not specified	Not specified	Not specified
SUPERVISION			
Who conducted supervision?	Psychologists	Senior clinicians	Not specified
What was the format of the supervision?	Monthly group supervision.	Not specified	Not specified
What supervision methods were used?	Not specified	Not specified	Not specified

TABLE 1. PART 2 CONTINUED

STUDIES	GLAVIN ET AL, 2010	MILGROM ET AL, 2011A	MILGROM ET AL, 2011B
TREATMENT CHARACTERISTICS			
How was treatment delivered? (remote, group, individual).	Face-to-face. 1-on-1 sessions in the well-baby clinic.	Remote support. Self-help workbook 'Towards Parenthood' supported by scheduled weekly phone calls from a psychologist / trainee.	Individual sessions delivered by the nurse in home / clinic and by psychologist in hospital.
How long was treatment? (intended vs actual).	1 session was offered to mothers with EPDS 10+. A further 2 – 7 sessions were offered if needed up to 3 months postpartum.	The 8 sessions were accessed over 8 weeks from 20 - 32 weeks gestation with the final unit accessed at 6 weeks post-partum.	6 weeks
How many sessions? (intended vs actual, min and max; booster sessions).	The number of sessions depended on the needs of the mother.	9 units; 8 telephone sessions with psychologist.	6 sessions
How long were the sessions (intended vs actual; min and max).	30 mins	30 mins	Not specified
Were sessions delivered in a temporal sequence?	No	Yes	Yes
Was the treatment manualised? (if so, provide URL)	Not specified	Yes	Yes
How was the quality of therapy assessed?	Not specified	A project manager ensured adherence to the study protocol.	Not specified
What is the no or percentage of individuals who completed the entire treatment package?	Of the 164 mothers in the IG, 108 received 1 supportive counseling session and 56 mothers received 2 – 7 sessions. 82% (186 / 228) women were retained in the study for the 3 month follow-up and 64% at the 6 month follow-up.	73% women with low screening scores completed 4+ sessions, 58% completed 8 sessions. 57% of high screening women completed 4+ sessions, 33% completed 8 sessions.	Mothers attended an average of 4.6 counseling sessions with the nurse and an average of 4 counseling sessions with the psychologist. 50 of the 68 participants returned post-study questionnaires.

TABLE 1. CHECKLIST OF KEY IMPLEMENTATION PROCESSES FOR PSYCHOLOGICAL TREATMENTS (SINGLA ET AL, 2017). (PART 3 OF 7)

STUDY	AMMERMAN ET AL, 2013
WHERE?	**SOUTH WESTERN OHIO AND NORTHERN KENTUCKY**
TREATMENT SETTING	
Rationale for setting.	Home visiting programmes provide support to at least 500,000 socially isolated, disadvantaged, low-income families in the USA. 28% - 61% of mothers in home visiting programmes report depressive symptoms. Depressed mothers find it harder to engage with home visiting services. Home visitors feel unprepared to deal with depressed mothers.
Barriers and facilitators related to setting	For interventions to be effective they need to be adapted to the unique features of the delivery setting. An adapted intervention delivered by specially trained social workers working in close collaboration with home visitors helped to increase engagement and retention in the intervention. CBT is the most frequently researched intervention and one of the most effective treatments for depression and was used as the foundation of the intervention.
WHO?	
Who delivered the treatment?	Masters level social workers
How were they selected?	Not specified
Rationale for selection	Not specified
Demographics (age, gender, experience)	Not specified
Compensation	Not specified
Certification process	Not specified
Is there access to an expert?	
What is the role of the expert?	

TABLE 1. PART 3 CONTINUED

STUDY	AMMERMAN ET AL, 2013
WHAT?	
Theoretical orientation.	Cognitive behavioural therapy; systems theory; attachment theory.
Treatment class.	Talking therapies; mother-infant interaction guidance; collaborative care.
TREATMENT COMPONENTS - ELEMENTS	
Non-specific.	
Specific.	Behavioural activation; cognitive restructuring; relapse prevention; stress management; adapting to parenthood; negotiating relationships; coping with the home environment; increasing maternal sensitivity to infant cues; changing maternal attributions of child behavior.
In-session techniques.	Developing assertive communication skills; coping strategies; use of daily activity schedule to promote behavioural activation; Cognitive restructuring techniques (+ thought records); motivational techniques / handouts (eg. ladder of success); using pictures of infant facial expressions to help mothers think about and respond to infant facial cues; using tracking charts to monitor infant sleep/wake cycles in order to adapt to biobehavioural rhythms and cues; observing mother-infant interactions; providing guidance about age –appropriate activities; goal setting; review of self-monitoring data-collection; assignment and review of homework.
Description of adaptations for specific context or target group.	CBT was adapted to the setting, context and population based on literature review and input from mothers and home visitors.
HOW - TRAINING	
Who conducted the training?	Not specified
How long was the training? (hours).	Not specified
What was the format of the training?	Not specified
What were the procedures for assessing competence?	Therapists completed self-report fidelity checklist indicating adherence to elements of CBT.

TABLE 1. PART 3 CONTINUED

STUDY	AMMERMAN ET AL, 2013
SUPERVISION	
Who conducted supervision?	Doctoral level clinician
What was the format of the supervision?	Review of cases and audiotaped sessions.
What supervision methods were used?	Not specified
Treatment characteristics	
How was treatment delivered? (remote, group, individual).	Individual sessions delivered in the home
How long was treatment? (intended vs actual)	19 weeks
How many sessions? (intended vs actual, min and max; booster sessions)	15 + 1 booster session (mothers completed mean of 11.2 sessions)
How long were the sessions (intended vs actual; min and max)	60 – 75 mins
Were sessions delivered in a temporal sequence?	Yes
Was the treatment manualised? (if so, provide URL).	Yes
How was the quality of therapy assessed?	Therapists completed self-report fidelity checklist indicating adherence to elements of CBT.
What is the no or percentage of individuals who completed the entire treatment package?	Mothers and home visitors completed surveys to indicate their satisfaction with the intervention. 48.9% of mothers completed the treatment.

TABLE 1. CHECKLIST OF KEY IMPLEMENTATION PROCESSES FOR PSYCHOLOGICAL TREATMENTS (SINGLA ET AL, 2017). (PART 4 OF 7)

STUDIES	O'MAHEN ET AL, 2013	NUGENT ET AL, 2014	O'MAHEN ET AL, 2014
WHERE?	**MICHIGAN, U.S.A.**	**NEW ENGLAND, U.S.A.**	**EXETER, ENGLAND**
TREATMENT SETTING			
Rationale for setting	Need to improve access to acceptable, effective treatments for perinatal depression, especially for low-income women. Multicomponent interventions have been found to improve adherence to treatment.	Accumulating evidence about the impact of maternal postnatal depression on parenting quality and the potential adverse consequences for the child has highlighted the need to think about how to foster positive mother-infant relationships in the context of maternal mental ill-health.	There are long waiting lists for mental health services and inequitable distribution of specialist perinatal mental health services across the country. Some studies have indicated that individuals are more likely to disclose sensitive information via on-line screening tools and may prefer the convenience of accessing an on-line intervention.
Barriers and facilitators related to setting	Psychological and practical factors act as barriers to accessing treatment. Treatment for perinatal MHPs was synchronised with routine obstetric appointments. Flexibility in treatment times and locations was offered as well as persistent outreach efforts to engage with the mother and liaise with family members and other services.	Effective interventions to address maternal mental health are not always available, accessible or acceptable to mothers. It is possible that interventions are initiated too late in the life of the infant who is so dependent on the nurturing capacity of an emotionally available caregiver. Relationship-enriching interventions may increase maternal self-efficacy and have a beneficial effect on maternal mood.	A previous study and qualitative survey of the views of women indicated that women wanted an intervention tailored to the particular circumstances of motherhood and consideration given to the demands on their time required from too many sessions or the need to complete homework. Telephone support was added in order to combat the high rates of attrition in the previous study.
WHO?			
Who delivered the treatment?	Masters and doctoral level social workers and psychologists.	3 Psychologists and 1 nurse.	Support from mental health workers with undergraduate degrees and a year of further training in 'low intensity' psychological therapies.
How were they selected?	Not specified	Not specified	Not specified
Rationale for selection	Treatment providers needed to have experience of treating perinatal depression and/or delivering CBT.	Not specified	Mental health workers were recruited from services responsible for delivering a nationwide programme – 'Improving Access to Psychological Therapies' (IAPT) and were therefore accustomed to providing telephone support.

TABLE 1. PART 4 CONTINUED

STUDIES	O'MAHEN ET AL, 2013	NUGENT ET AL, 2014	O'MAHEN ET AL, 2014
WHO?			
Demographics (age, gender, experience).	Not specified	Not specified	Not specified
Compensation	Not specified	Not specified	Not specified
Certification process	Not specified	Yes	Not specified
Is there access to an expert?	Yes	Yes	Yes
What is the role of the expert?	Clinical supervisor for research project	The principal investigator developed the intervention and wrote the training manual.	Principal investigator (also clinical psychologist and specialist in perinatal depression and behavioural activation).
WHAT?			
Theoretical orientation	Cognitive Behavioural therapy; Motivational interviewing.	Mother-infant interaction guidance.	Behavioural activation.
Treatment class	Talking therapies	Relationship focused intervention	Talking therapies
TREATMENT COMPONENTS - ELEMENTS			
Non-specific	Maintaining positive relationships with family members and other service providers.	Not specified	Not specified
Specific	Psychoeducation; motivational interviewing; Behavioural activation; goal setting; cognitive restructuring; interpersonal support; active outreach.	The intervention – the neonatal behavioural observation (NBO) consists of 18 neurobehavioural observations that provides insight into the unique strengths, capabilities and behavioural profile of the infant as well as how they manage transitions between sleep and awake states. This information can then be used to inform parental responses and interactional style. Confidence in being able to interpret infant cues is also likely to enhance maternal self-efficacy and competency.	Intervention called 'Helping with Depression'. Psychoeducation; behavioural activation; problem-solving and prioritising; exploring mother- infant relationship; coping with motherhood; developing communication skills; managing transitions; activating support networks; sleep achievement strategies; managing unhelpful thoughts; overcoming anxiety.

TABLE 1. PART 4 CONTINUED

STUDIES	O'MAHEN ET AL, 2013	NUGENT ET AL, 2014	O'MAHEN ET AL, 2014
TREATMENT COMPONENTS - ELEMENTS - CONTINUED			
In-session techniques	Functional analytic approach to understand actions that undermine goal-directed behaviours or supportive relationships; engagement strategies to overcome barriers to participation in treatment; activity scheduling; facilitating self-monitoring; helping mothers to achieve balance in valued activities; helping mother to develop alternative interpersonal strategies.	Specific sequence of assessments/observations; generation of mutual understanding of infant's unique personality, temperament, needs, strengths and capabilities; identification of techniques to promote positive mother-infant interaction; collaborative development of maternal – infant caregiving plan.	Interactive exercises paired with worked examples, access to a chat room.
Description of adaptations for specific context or target group	The content of the intervention was adapted to the needs of perinatal women as a result of a qualitative survey of women's views, piloting of the adapted version with 11 women and further refinement by experts in CBT and perinatal depression.	The NBO was developed to extend the clinical application of the Neonatal Behavioural Assessment Scale (NBAS) by reducing the number of assessments and decreasing the time required to conduct the intervention.	A group of stakeholders worked with the researchers to develop a more acceptable, less demanding intervention. The original 12 session course was presented in a modular format with the option of mothers to choose 2 out of 6 additional modules having completed a core module.
HOW - TRAINING			
Who conducted the training?	No formal training. Treatment providers were required to familiarize themselves with the treatment manual and then review the manual and key concepts with principal research investigator or clinical supervisor and deliver one treatment under supervision.	The principal investigator is the author of the training manual. The training received by the other interventionists is not specified.	Principal investigator (also clinical psychologist and specialist in perinatal depression and behavioural activation) plus IAPT trainer.
How long was the training? (hours)	Not specified	Not specified	5 days of training in the perinatal specific behavioural activation approach.
What was the format of the training?	Not specified	Not specified	Mix of didactics and role play around conducting functional analysis in perinatal-specific domains.
What were the procedures for assessing competence?	Providers completed the programme with 1 mother under close supervision. 10% of randomly selected audiotapes of intervention sessions were assessed with the revised cognitive therapy scale.	Not specified	Sessions were audiorecorded and reviewed in supervision sessions.

TABLE 1. PART 4 CONTINUED

STUDIES	O'MAHEN ET AL, 2013	NUGENT ET AL, 2014	O'MAHEN ET AL, 2014
SUPERVISION			
Who conducted supervision?	Not specified.	Not specified.	Principal investigator
What was the format of the supervision?	Format not specified. Weekly sessions.	Not specified.	Not specified.
What supervision methods were used?	Review of audiotapes of therapy sessions.	Not specified.	Not specified.
TREATMENT CHARACTERISTICS			
How was treatment delivered? (remote, group, individual).	Individual, flexible locations (home/office)	I session with the mother and baby in hospital before discharge from the maternity ward, 1 session with the mother and baby at home at 1 month postpartum.	Remote – online sessions PLUS weekly telephone sessions from mental health worker.
How long was treatment? (intended vs actual)	Approx 12 weeks	1 month	12 weeks
How many sessions? (intended vs actual, min and max; booster sessions)	Up to 12 sessions	2	6 on-line modules. 12 phone supportive phone calls.
How long were the sessions (intended vs actual; min and max)	50 mins	12 – 25 mins	50 mins for introductory phone call, Approx 30 mins for subsequent phone calls.
Were sessions delivered in a temporal sequence?	Yes	Not applicable	Yes
Was the treatment manualised? (if so, provide URL)	Yes	Yes	Yes – each mental health worker had a sessional support guide.

TABLE 1. PART 4 CONTINUED

STUDIES	O'MAHEN ET AL, 2013	NUGENT ET AL, 2014	O'MAHEN ET AL, 2014
SUPERVISION - CONTINUED			
How was the quality of therapy assessed?	10% of audiotaped cases were assessed for fidelity to the model by the clinical supervisor.	Not specified	Sessions were audiorecorded. 20% of the sessions were monitored weekly for adherence to the content.
What is the no or percentage of individuals who completed the entire treatment package?	24% (7/30) women completed all 12 sessions of the intervention. 83% (25/30) attended the first session.	93% (53 / 57) were followed up for the 1 month intervention and assessment.	5% of mothers completed 8+ computer sessions 1.9% of mothers completed 12 computer sessions. The mean number of completed telephone support sessions was 8.

TABLE 1. CHECKLIST OF KEY IMPLEMENTATION PROCESSES FOR PSYCHOLOGICAL TREATMENTS (SINGLA ET AL, 2017). (PART 5 OF 7)

STUDIES	GROTE ET AL, 2015	SEGRE ET AL, 2015	GOODMAN ET AL, 2015
WHERE?	KING COUNTY, WASHINGTON, U.S.A.	MID WEST, U.S.A.	MASSACHUSETTS, BOSTON, U.S.A.
TREATMENT SETTING			
Rationale for setting	Racially / ethnically diverse women on low incomes are more prone to perinatal mental health problems and more difficult to engage and retain in minimally adequate treatment.	Impoverished women least likely to receive treatment for depression. Mothers are more likely to engage with treatment if it is delivered by a familiar professional in an accessible location.	Maternal MHPs can have an impact on the way a mother thinks about, interacts with and cares for her baby. This can have short-, medium- and long-term adverse outcomes for the baby. Interventions focused entirely on maternal depression do not necessarily change the way the mother interacts with her baby. Interventions targeting compromised maternal-infant interactions, in the context of maternal depression, may not improve maternal mental health. An integrated approach that simultaneously addresses both problems is needed.
Barriers and facilitators related to setting	Barriers include a culturally insensitive / stigmatizing environment; lack of healthcare providers of different ethnicities; high staffing ratios; long waiting times; difficulty in accessing treatment if it requires transport or childcare; distrust of health services. Maternity support services in King County provide a comprehensive programme of support to mothers identified with additional needs during pregnancy or the year after delivery. Despite having a system whereby mothers who score 10+ on the PHQ9 are referred for mental health treatment in the community, only a minority of depressed pregnant women benefit from this service.	Barriers include the vulnerable status of non-documented immigrants. It was difficult to recruit mothers to this study. It took 36 months to identify 99 women with scores of 12+ on the EPDS who expressed a willingness to participate in the trial. It was anticipated that treatment provided by existing trusted and familiar providers to mothers in their homes might increase the number of mothers willing to engage with treatment.	Effective interventions for maternal depression exist but they can be difficult to access, or not acceptable to mothers, for various reasons. Home-based, nurse-delivered interventions have proven effective in improving maternal and child health outcomes.

TABLE 1. PART 5 OF 7 CONTINUED

STUDIES	GROTE ET AL, 2015	SEGRE ET AL, 2015	GOODMAN ET AL, 2015
WHO?			
Who delivered the treatment?	Masters level social workers designated as Depression Care Specialists (DCS)	Home visitors or physician's assistant with bachelors or masters degree in relevant topics including psychology, sociology, social work, nursing.	Maternal-child health nurses without previous mental health experience.
How were they selected?	Not specified	Employed as point-of-care providers delivering home visits or prenatal care at study sites.	Not specified
Rationale for selection	Previously worked in maternal support services.	Relevant experience.	Home visits, delivered by nurses, have been shown to be an effective means for delivering social and psychological support to mothers.
Demographics (age, gender, experience)	Not specified	26 providers. All Female; average age 35 years; 85% white Caucasian, 8% African American; $% Asian; 4% multiracial; 31% Hispanic / Latino. 42.3$ were bilingual – English / Spanish. On average, point-of-care providers had been in their occupations for an average of 58.04 months and had been at their current position 38.46 months. The majority of providers reported that mental health was a significant element in their training with 50% having had some training in counseling.	Not specified
Compensation	Not specified	Not specified	Not specifed
Certification process	Not specifed	Not specified	Not specifed
Is there access to an expert?	Yes	Yes	Yes
What is the role of the expert?	Weekly meetings between the DCS's, principal investigator and team psychiatrist.	All sites had telephone access to the principal investigator	Principal investigator

TABLE 1. PART 5 OF 7 CONTINUED

STUDIES	GROTE ET AL, 2015	SEGRE ET AL, 2015	GOODMAN ET AL, 2015
WHAT?			
Theoretical orientation	Ethnographic interviewing; motivational interviewing; Interpersonal psychotherapy;	Non-directive counseling	Mutual regulation model of mother-infant interaction (Tronick, 2007); psychoanalytic theory (Winston et al, 2004); mother-infant psychotherapy (Lieberman et al, 2000). Touchpoints model of child development (Brazelton & Sparrow, 2006)
Treatment class	Psychological Therapies; Collaborative Care	Psychological therapies	Talking therapies; Mother-infant interaction guidance.
TREATMENT COMPONENTS - ELEMENTS			
Non-specific	Reflective listening; affirming strengths.	Active reflective listening	A positive, nurturing, non-judgemental relationship that provides 'a safe holding environment in which the new mother feels encouraged, validated, and psychologically supported to grow in self-knowledge and understanding of her child.' (Goodman et al, 2013, p.300). Active listening; reassurance; encouragement, praise; empathy; normalization.
Specific	The MOMCare intervention is a multi-component, collaborative care intervention facilitating choice of brief IPT and/or antidepressants. Educational material provided: The Depression Help Book. Pre-treatment engagement session; psychoeducation; mood monitoring; strengthening social supports, behavioural activation; case management; medication monitoring; relapse prevention.	Intervention described as 'Listening Visits' (LVs) Includes empathic listening to gain a full understanding of a woman's situation; collaborative problem-solving to generate an action plan.	Anticipatory guidance (to ameliorate psychiatric symptoms and anticipate infant developmental progression and changing abilities and needs); mother-infant interaction guidance to enhance maternal responsiveness and promote positive mother-infant interactions; fostering maternal competence and confidence; mood monitoring; problem-solving; behavioural activation; maternal self-care; exploring family dynamics and social networks; observing and responding to environmental assets and challenges.

TABLE 1. PART 5 OF 7 CONTINUED

STUDIES	GROTE ET AL, 2015	SEGRE ET AL, 2015	GOODMAN ET AL, 2015
TREATMENT COMPONENTS - ELEMENTS - CONTINUED			
In-session techniques	Building on mother's strengths and helpful coping strategies; facilitating resolution of interpersonal issues. enabling access to community resources.	Not specified	Shared observations and co-construction of meaning of infant behavior between nurse and mother; identifying and building on moments of mother-infant connection; recognizing and positively re-inforcing positive maternal behaviours and unique knowledge and expertise of the mother; encouragement of developmentally appropriate care and play; exploration of the meaning of 'motherhood'; enhancement of maternal awareness of own needs and her ability to meet them; exploring stressors, response to stress and ways of managing stress; activity scheduling; talking about feelings; discussing options for managing unhelpful thoughts; encouraging interactions with friends and family and participation in pleasant activities; goal setting.
Description of adaptations for specific context or target group	Pre-therapy engagement session to help resolve barriers to care; offering patient ongoing support regardless of choice of intervention; intensive outreach to facilitate engagement and retention.	Adapted from 'Listening Visits' Intervention developed in the U.K.	The intervention was developed as a result of consultation with a range of experts and piloting of the intervention with 3 non-depressed mothers.

TABLE 1. PART 5 OF 7 CONTINUED

STUDIES	GROTE ET AL, 2015	SEGRE ET AL, 2015	GOODMAN ET AL, 2015
HOW - TRAINING			
Who conducted the training?	Various members of the research and clinical team.	Principal investigator	Principal investigator
How long was the training? (hours)	Initial 2 week training in the engagement session, motivational interviewing, culturally relevant IPT, case management and general information on perinatal complications and pharmacotherapy. PLUS monthly training on relevant topics PLUS self-study of 4 manuals: engagement manual, brief IPT manual, pharmacotherapy manual, and depression care by phone manual.	2 x 7 hour training workshops. Topics included: prevalence, diagnosis, screening, referral and treatment of depression; skills required to deliver, and implementation of, LVs.	10 days: 3 days touchpoint training; 1 day neonatal behavioural observation training; 6 days training to deliver the intervention.
What was the format of the training?	Didactic presentations; watching videos; role play.	Didactic presentations; videos; role play.	Didactic; video observations; videotaped role play with individualized feedback.
What were the procedures for assessing competence?	Audiotapes of sessions with training 'cases' evaluated to determine fidelity to the model.	Consultation with a mental health professional was provided to LV providers for every 2 LV sessions in 3 out of the 4 locations.	In the pilot: Videotaped intervention sessions that were coded for adherence to the intervention protocol and competence in delivering the intervention elements. with feedback to nurses from the principal investigator.
SUPERVISION			
Who conducted supervision?	Weekly group supervision from Team psychiatrist and weekly individual supervision from the principal investigator.	Not specified	Principal Investigator
What was the format of the supervision?	Not specified	Not specified	Weekly case discussions and review of intervention sessions.
What supervision methods were used?	Weekly supervision included review of audiotapes and case discussion.	Not specified	Not specified

TABLE 1. PART 5 OF 7 CONTINUED

STUDIES	GROTE ET AL, 2015	SEGRE ET AL, 2015	GOODMAN ET AL, 2015
TREATMENT CHARACTERISTICS			
How was treatment delivered? (remote, group, individual).	Flexible delivery. By phone, public health centres, other community centres or In the mother's home.	Home or health centre	Individual (home)
How long was treatment? (intended vs actual).	Up to 18 months	8 weeks	3 months (weekly for the first 4 weeks, then fortnightly)
How many sessions? (intended vs actual, min and max; booster sessions).	8 acute IPT sessions offered every 1-2 weeks by phone or in-person during the 1st 3-6 months, and monthly during the maintenance phase (up to 18 months)	6	8 sessions
How long were the sessions (intended vs actual; min and max).	Av length of home visit = 45 – 60 mins Av length of phone call = 20 – 30 mins	30 – 50 mins	60 mins
Were sessions delivered in a temporal sequence?	Not specified	No	Yes
Was the treatment manualised? (if so, provide URL).	Yes	Not specified	Yes
How was the quality of therapy assessed?	The Principal Investigator used the IPT raying scale to review 75% of the engagement and brief IPT sessions.	Consultation with a mental health professional was provided to LV providers for every 2 LV sessions in 3 out of the 4 locations.	Weekly team meetings to discuss cases and intervention fidelity.
What is the no or percentage of individuals who completed the entire treatment package?	84% of the 81 mothers in the intervention group received 8+ sessions of IPT. 79% of mothers had at least 1 booster session through the 18 months follow up.	82% participants completed between 4 and 6 sessions. 90% completed the 8 week outcome assessment.	At least 7 out of the 8 sessions were completed by all of the participating mothers.

TABLE 1. CHECKLIST OF KEY IMPLEMENTATION PROCESSES FOR PSYCHOLOGICAL TREATMENTS (SINGLA ET AL, 2017). (PART 6 OF 7)

STUDIES	ZLOTNICK ET AL, 2016	SAMPSON ET AL, 2016	GLASSER ET AL, 2016
WHERE?	**PROVIDENCE, RHODE ISLAND, U.S.A.**	**HOUSTON, TEXAS, U.S.A.**	**ULTRA-ORTHODOX JEWISH COMM', ELAD, ISRAEL**
TREATMENT SETTING			
Rationale for setting	Postpartum depression is more prevalent amongst low-income women. During pregnancy women are motivated to make changes for the benefit of the baby.	Family service programmes, that include a home visiting component, provide an ideal opportunity to reach low-income women, who are particularly vulnerable to mental health problems, but difficult to engage and retain in mental health interventions.	Universal perinatal screening and intervention programmes need to be tailored to the needs of particular cultural groups. Understanding the factors that influence the way that symptoms are experienced and described in different cultures contributes to the development of more appropriate assessments and acceptable interventions.
Barriers and facilitators related to setting	Limited access to effective, acceptable treatments and the stigma associated with mental illness means that many women do not receive treatment. Delivering the intervention in antenatal clinics to co-ordinate with routine antenatal appointments improves access. The emphasis of the intervention as an educational programme and avoidance of reference to depression helps to reduce stigma.	Focus groups with mothers as part of another study revealed high levels of stigma around postnatal depression that prevented mothers from admitting symptoms or seeking treatment. Routine screening for PPD is offered and 30% of women are eligible for a community –based counseling intervention. Less than a third access the treatment.	The ultra-orthodox Jewish communities are guided by strict cultural practices and expectations that include limited trust in non- orthodox institutions. This may constrain the ability of individuals to share symptoms with 'outsiders'. The Ministry of Health (Israel) has mandated that all pregnant and postpartum women should be screened for depression. National guidelines support the provision of non-directive counseling by clinic nurses.
WHO?			
Who delivered the treatment?	1 nurse and 2 individuals educated to Bachelor level.	Caseworkers (social workers)	Maternal-Child health Clinic nurses
How were they selected?	Not specified	Not specified	Employed by health service
Rationale for selection	Clinicians accustomed to working in antenatal clinics.	Already employed in a Healthy Start programme.	Intervention to be include as part of routine care
Demographics (age, gender, experience)	Not specified	Not specified	Not specified

TABLE 1. PART 6 OF 7 CONTINUED

STUDIES	ZLOTNICK ET AL, 2016	SAMPSON ET AL, 2016	GLASSER ET AL, 2016
WHO? CONTINUED			
Compensation	Not specified	Caseworkers who delivered the intervention to at least 4 mothers were rewarded with a Kindle Fire.	Not specified
Certification process	Not specified	Not specified	Not specified
Is there access to an expert?	Yes	Graduate level research assistant visited the provider agency weekly.	Not specified
What is the role of the expert?	Principal investigator of research study/research team	Check on caseworkers and offer any help needed.	Not specified
WHAT?			
Theoretical orientation	Interpersonal Therapy/Educational framework	Cognitive Behavioural Therapy; Motivational Interviewing	Non-directive counselling
Treatment class	Psychological therapies	Talking therapies	Talking therapies
TREATMENT COMPONENTS - ELEMENTS			
Non-specific	The ROSE intervention – (Reach Out, Stay Strong, Essentials for new mothers) focuses on psychoeducation, managing stress, increasing social support, developing conflict- calming communication skills in order to negotiate and enhance intimate partner relationships; activating social support networks.	Not specified	

TABLE 1. PART 6 OF 7 CONTINUED

STUDIES	ZLOTNICK ET AL, 2016	SAMPSON ET AL, 2016	GLASSER ET AL, 2016
TREATMENT COMPONENTS - ELEMENTS - CONTINUED			
Specific	Scripted guides for interventionists. Handouts and homework for each session.	The caseworkers used a 'script' to guide the motivational interviewing session. This session included exercises to assess the mother's motivation to accept treatment. Each problem-solving session included progress up-date, topic discussion and goal setting. Between session homework involved putting into action the steps agreed in the session to solve the identified problem. Mother's were also given handouts to help them to manage their depression between sessions.	Discussion of thoughts and emotions; transition to parenthood; changes in life patterns and relationships; organization of daily activities; problem solving; encouragement for positive changes.
In-session techniques	A flexible approach to delivery includes option of group/ individual sessions, home or office sessions, timing and order of the sessions, open enrolment, splitting or lumping together of sessions and opportunities to catch up on mixed content.	Not specified	Not specified
Description of adaptations for specific context or target group	The ROSE intervention – (Reach Out, Stand Strong, Essentials for new mothers) focuses on psychoeducation, managing stress, increasing social support, developing conflict- calming communication skills in order to negotiate and enhance intimate partner relationships; activating social support networks.	Adaptation of a problem solving therapy programme used by the University of Washington combined with elements from a 'Nurses for Newborn' programme. Adaptation involved calling it problem-solving tools not therapy, reducing the number of sessions from 8 to 4,training social workers rather than nurses to deliver it, and preceding the intervention with 1 motivational interviewing session.	

TABLE 1. PART 6 OF 7 CONTINUED

STUDIES	ZLOTNICK ET AL, 2016	SAMPSON ET AL, 2016	GLASSER ET AL, 2016
HOW? TRAINING			
Who conducted the training?	Not specified	Lead investigator and external consultant who was an expert in problem-solving therapy.	Psychologist and social worker with expertise in perinatal mental health and knowledge of the ultra-orthodox community.
How long was the training? (hours)	Not specified	1.5 days	6 hours
What was the format of the training?	Not specified	Not specified	Not specified
What were the procedures for assessing competence?	Not specified	Caseworkers declined to audiorecord sessions as they said their clients were too 'paranoid' and would resent the intrusion.	The intervention was practiced during 2-3 hour training sessions and monitored by the nurse supervisor to ensure adherence to Ministry of Health guidelines.
SUPERVISION			
Who conducted supervision?	Not specified	Not specified	Not specified
What was the format of the supervision?	Not specified	Not specified	Not specified
What supervision methods were used?	Not specified		Not specified
TREATMENT CHARACTERISTICS			
How was treatment delivered? (remote, group, individual)	Group/ individual sessions with flexibility to adapt to 1-on-1 delivery.	Individual. Home.	To individual mothers in the clinic.
How long was treatment? (intended vs actual)	Delivered over a 4-week period with individual booster session 2 weeks after delivery.	5 weeks	Sessions were offered weekly for as long as considered necessary by mutual agreement between the mother and the nurse.

TABLE 1. PART 6 OF 7 CONTINUED

STUDIES	ZLOTNICK ET AL, 2016	SAMPSON ET AL, 2016	GLASSER ET AL, 2016
TREATMENT CHARACTERISTICS - CONTINUED			
How many sessions? (intended vs actual, min and max; booster sessions)	4 group sessions + 1-on-1 session.	5	Not specified
How long were the sessions (intended vs actual; min and max)	Group – 90 minutes 1-on-1 session – 50 minutes	Not specified	Not specified
Were sessions delivered in a temporal sequence?	Yes (but flexibility is permitted).	Yes	No
Was the treatment manualised? (if so, provide URL)	Intervention providers are given a manual, patient handouts, summary of key components and scripts for presenting the programme.	Yes	Not specified
How was the quality of therapy assessed?	Not specified	Caseworkers declined to audiorecord sessions as they said their clients were too 'paranoid' and would resent the intrusion.	Not specified
What is the no or percentage of individuals who completed the entire treatment package?	An average of 3.5/5 sessions were completed by mothers in the intervention group. 16% (32/205) of women dropped out of the study.	93% (13/14) retention rate, 100% completion of homework	Not specified

TABLE 1. CHECKLIST OF KEY IMPLEMENTATION PROCESSES FOR PSYCHOLOGICAL TREATMENTS (SINGLA ET AL, 2017). (PART 7 OF 7)

STUDIES	HOLT ET AL, 2017	TANDON ET AL, 2018	FUHR ET AL, 2019
WHERE?	**THREE MUNICIPALITIES, VICTORIA, AUSTRALIA**	**ILLINOIS, U.S.A.**	**GOA, INDIA**
TREATMENT SETTING			
Rationale for setting	Poor uptake of treatments by pregnant or postnatal women with anxiety or depression. Barriers include difficulty recognizing symptoms; shame; stigma; the nature of the relationship with health professionals and lack of knowledge about available treatments.	Low-income women are disproportionately affected by perinatal depression. It is important to identify mothers at the earliest possible opportunity and offer treatment in order to reduce the chances of adverse effects on the child. The presence of symptoms that do not meet diagnostic criteria also lead to adverse maternal and infant outcomes.	In low resource settings, lack of health workers and health system infrastructure, 90% of women with perinatal depression remain untreated. In response to these issues, the World Health Organisation devised a low intensity intervention 'Thinking Healthy' that could be delivered by non-mental health specialists.
Barriers and facilitators related to setting.	Maternal and child health (MCH) nurses have regular consultations with mothers and therefore are ideally placed to help women engage with treatments.	Home visiting services provide a mechanism for engaging with low-income mothers. Depressed clients require more effort to engage in services and home visitors may not feel competent or confident in their ability to provide appropriate support. Interventions targeting maternal depression have been successfully integrated into home visiting services.	In some low and middle-income countries community health workers were trained to deliver this intervention. Limitations on the capacity of community health workers meant that it has been difficult to 'scale up' the intervention. Non-specialist health workers trained to deliver a psychological intervention can effectively manage perinatal depression, in resource-constrained settings.
WHO?			
Who delivered the treatment?	Maternal and Child Health Nurses	Home visitors	Mothers from the local community
How were they selected?	Employed in local health services		Recruited as a result of recommendations from key informants in the local self-help groups or who were already involved in supporting mothers with young children. Selected for their good communication skills.
Rationale for selection	Routine contacts with all mothers		Mothers with good communication skills who expressed a desire to help other mothers. Called Sakhis – which translates to 'friend' in Hindi.

TABLE 1. PART 7 OF 7 CONTINUED

STUDIES	HOLT ET AL, 2017	TANDON ET AL, 2018	FUHR ET AL, 2019
WHO? - CONTINUED			
Demographics (age, gender, experience)	Not specified	Demographic data was available for 68/75 home visitors. All female. Av age: 42 years. Av length of time working as a home visitor: 8.8 years. Majority had minimum 2-year Associate degree. 36% were African American; 34% white; 25% Latina; 3% Asian American; 2% biracial.	Middle-aged women with children, from the same socio-demographic background as the mothers eligible for the support.
Compensation	Usual pay		Incentives provided, but not clearly specified.
Certification process	Not specified		Only Sakhis who passed the competency assessment at the end of their internship were selected to deliver the programme.
Is there access to an expert?	Yes		Yes
What is the role of the expert?	Provide supervision by phone		Provide supervision.
WHAT?			
Theoretical orientation	Motivational interviewing	Cognitive Behavioural Therapy	Cognitive Behavioural Therapy (CBT)
Treatment class	Talking therapies	Talking therapies	Talking therapies

TABLE 1. PART 7 OF 7 CONTINUED

STUDIES	HOLT ET AL, 2017	TANDON ET AL, 2018	FUHR ET AL, 2019
TREATMENT COMPONENTS - ELEMENTS			
Non-specific	Open-ended questions and reflective statements; summarizing; re-inforcing strengths; empathy.	Cognitive Behavioural Therapy Talking therapies	Empathy; good communication skills; genuine interest; encouragement.
Specific	The PRIMER intervention (Promoting Motivation, Empowerment and Readiness). Motivational interviewing.	'Mothers and Babies course aims to help mothers engage in healthy ways to manage their internal (thoughts, hopes and feelings) and external reality (what happens in their world) Behavioural activation; restructuring harmful cognitions; problem-solving; increasing social support.	Thinking Healthy programme has three main areas of focus: personal health of the mother; her relationship with the baby; her relationship with others. The programme is guided by the principles of CBT. Includes psychoeducation; behavioural activation.
In-session techniques	Checking how the mother is coping and ensuring that she feels heard and understood; assessing how important it is to the mother to make changes; exploring what mother thinks might be helpful and providing information about local services and community resources; assessing level of commitment to making changes and supporting mother to take initial steps.	Identifying stressors and ways of coping; identifying pleasant activities; practicing relaxation techniques; managing unhelpful thoughts, balancing negative thoughts with positive ones; identifying people who can help and the sort of help they can provide; exploring how mood affects communication and strategies to improve communication style to secure support from friends and family and manage conflict.	Monitoring mood and progress; helping mothers to identify unhelpful thinking, attitudes and cultural practices and explore ways of modifying their thoughts; helping mother to identify and practice the actions she needs to take to keep herself and her baby healthy; promoting positive, sensitive, responsive mother-infant interactions; helping mother to overcome any problems and mobilise support from partner, friends, family and the local community.
Description of adaptations for specific context or target group	The intervention was developed by two of the authors as a result of a review of the literature and attendance at various training workshops and conferences on motivational interviewing.	An existing effective group intervention (Mothers-and- Babies) for low-income mothers was adapted for delivery on an individual basis.	The original 'Thinking Healthy' programme was adapted for delivery by peers by narrowing the focus from CBT to behavioural activation and reducing the number of sessions.

TABLE 1. PART 7 OF 7 CONTINUED

STUDIES	HOLT ET AL, 2017	TANDON ET AL, 2018	FUHR ET AL, 2019
HOW? TRAINING			
Who conducted the training?	Not specified	The first author and developer of the Mothers-and-Babies intervention.	Not specified
How long was the training? (hours)	12 hours - Delivered over 2 days separated by 1-2 weeks to allow time for practice.	1.5. days	25 – 40 hours
What was the format of the training?	Not specified	Didactic sessions; small and large group activities; personal project presentations; role-play. Content included: orientation to the principles of CBT, guided exploration of the sessions in the instructor and participant manuals.	Interactive sessions including discussion and role-plays. Content included: relationship building skills, guided exploration of the manual; dealing with difficult situations, recognizing symptom deterioration and serious adverse events.
What were the procedures for assessing competence?	MCH nurses completed an intervention checklist after every PRIMER visit to indicate adherence to the PRIMER manual.	Home visitors and mothers asked to complete surveys after each session to assess content and acceptability of the session.	At the end of a period of internship during which time Sakhis delivered 2-4 sessions to at least 2 mothers, competence was assessed using standardized role-plays and predefined competence assessments.
SUPERVISION			
Who conducted supervision?	Not specified	The first author/principal investigator.	Not specified
What was the format of the supervision?	The MCH nurses were offered a follow-up phonecall, 2-4 weeks after completing the training to provide supervision in delivering the intervention.	Each HV programme received bi-weekly phone supervision for the first 4-6 months of implementation.	Fortnightly group supervision (4 – 5 Sakhi's) once a month with a supervisor and once a month without a supervisor.
What supervision methods were used?	Not specified	Not specified. Opportunity to share and receive feedback about content and implementation.	Review of audiotapes of sessions. Discussion of challenges and opportunities.

TABLE 1. PART 7 OF 7 CONTINUED

STUDIES	HOLT ET AL, 2017	TANDON ET AL, 2018	FUHR ET AL, 2019
TREATMENT CHARACTERISTICS			
How was treatment delivered? (remote, group, individual)	In the clinic or home with individual mothers as part of routine developmental assessments.	MB sessions were delivered at the beginning or end of a scheduled home visit or over the phone if there was insufficient time in the visit.	The intervention was delivered in the mother's home unless she expressed a preference to have it delivered somewhere else.
How long was treatment? (intended vs actual)	12 weeks	Recommended that sessions be delivered every 1-2 weeks although they can be offered more frequently at the discretion of the home visitor. Therefore maximum duration of the programme is 30 weeks	Prenatal phase: 1 – 6 sessions 0 – 2 months postpartum: 1 – 4 sessions 3 – 4 months postpartum: 2 sessions 5 – 6 months postpartum: 2 sessions
How many sessions? (intended vs actual, min/max; booster sessions)	3 sessions	15	6 – 14 participants attended an average of 9.8 sessions
How long were the sessions (intended vs actual; min and max)	Not specified	15 – 20 mins	30 – 45 mins mean duration of attended sessions was 38 mins
Were sessions delivered in a temporal sequence?	No	Yes	Yes
Was the treatment manualised? (if so, provide URL)	Yes	Yes	Yes
How was the quality of therapy assessed?	Not specified	Home visitors completed a survey at the end of each MB session indicating how much of the manualised session was delivered, how it was received by the client and any challenges they visitor in discussing session topics.	Audiorecordings of 5% of sessions were rated on the Therapy Quality Scale by raters experienced in CBT. The mean score across 18 items was used to assess the quality of therapy delivery.
What is the no or percentage of individuals who completed the entire treatment package?	87.9% of women completed the 12-month post birth questionnaire. Reports of adherence to the manual by MCH nurses imply that 82 – 86% of eligible mothers were offered the PRIMER intervention at the 3 designated times.	Home visitors reported they completely covered 87.9% of the sessions they delivered.	71.7% met the criteria for treatment completion (attendance at a minimum of 6 sessions with at least 1 session in each of the 4 phases).

CHECKLIST DEVELOPED BY SINGLA ET AL (2017)

Appendix 2 Documentation relating to survey of health visitors – relevant to Chapter 7

2.1 Ethics Approval

5. 1. Ethics approval

OXFORD BROOKES UNIVERSITY

Oxford Brookes University

Faculty of Health and Life Sciences

Decision on application for ethics approval

The Departmental Research Ethics Officer (DREO) / Faculty Research Ethics Committee (FREC) has considered the application for ethics approval for the following project:

Project Title: An examination of health visitor 'listening visits' in the context of their role in supporting mothers with mental health problems

FREC Study Number: 2014/58

Name of Applicants: Catherine Lowenhoff

Name of Supervisor: Professor Jane Appleton

Please tick one box

1. The Faculty Research Ethics Committee gives ethical approval for the research project. √ ☐

Please note that the research protocol as laid down in the application and hereby approved must not be changed without the approval of the DREO / FREC

2. The Departmental Research Ethics Officer / Faculty Research Ethics Committee gives ethical approval for the research project, subject to the following: ☐

3. The Departmental Research Officer / Faculty Research Ethics Committee cannot give ethical approval for the research project. The reasons for this and the action required are as follows: ☐

Signed: HZAbbott Hazel Abbott ……

Approval Date: ……25 February 2016 ……...

Designation: Departmental Research Ethics Officer

(Signed on behalf of the Faculty Research Ethics Committee)

Date when application reviewed (*office use only*): …… 7 July 2015 ……..

2.2 Letter from iHV

5.2. Letter from the IHV

Institute of Health Visiting
Royal Society for Public Health
John Snow House
59 Mansell St
London
E1 8AN

26 3 2015

To : Whom it May Concern

RE : Catherine Lowenhoff
PhD student
Faculty of Health and Life Sciences
Department of Psychology, Social Work and Public Health
Oxford Brookes University

Supervisor : Dr Jane Appleton

I confirm that the above named student can have access to members of the Institute of Health Visiting via myself, but not direct access, in order to explore the topic of her doctoral study 'How do Health Visitors Approach Listening Visits?'

This will include indirect access to our members and distribution of an electronic survey on her behalf providing that the research proposal is approved by the university research ethics committee. Our members can be approached on her behalf and then opt into any other part of the study directly themselves.

Yours faithfully

Dr Cheryll Adams
Director
Institute of Health Visiting

2.3 Participant Information Sheet – distributed with paper version of survey

5.3. Participant Information sheet – distributed with paper version of survey.

OXFORD BROOKES UNIVERSITY

Participant Information Sheet - Paper questionnaire

Title of Research
An examination of health visitor 'listening visits' in the context of their role in supporting mothers with mental health problems.

What do I need to know?
You are being invited to take part in a research study. Before you decide whether or not to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully.

What is the purpose of the study?
The purpose of this study is to find out from health visitors themselves about what they think about the concept of 'listening visits' as a therapeutic package of support for mothers with mental health problems. This is phase I of the research and involves inviting health visitors to participate in a survey.

Why have I been invited to participate?
You have been invited to take part because you are a member of the Institute of Health Visiting.

Do I have to take part?
It is up to you to decide whether or not to take part. Please tick the circles next to the statements at the end of the survey consent form to indicate that you agree that you understand your rights and consent to take part. If you decide to take part you are still free to withdraw without giving a reason up to the point at which you return the questionnaire. A stamped addressed envelope is provided for this purpose. Returning the questionnaire confirms that you are happy for your data to be included in the analysis. As you are not required to give your name or place of work, your answers are anonymous.

What will happen to me if I take part?
If you choose to take part, you will be asked to complete the questionnaire as a paper copy. The questionnaire will take about 30 minutes to complete. The closing date for return of paper questionnaires is the 14th April.

What are the possible benefits of taking part?
There will be no direct benefits to you but this research may help to generate a better understanding of the health visitor's role in supporting women with mental health problems. This could lay the foundation for further research that might improve health visiting practice and thereby possibly improve outcomes for mothers and babies.

Will what I say in this study be kept confidential?
We will not ask for your name or contact details as part of this questionnaire and you will therefore be anonymous to the researchers. However, your answers to any open (write-in) questions could be quoted in publications. We also ask for the first three – four characters of your work postcode to get a better idea of the spread of participants across the country; we may publish a map of the spread of participants.

Data generated by the study will be retained for a period of ten years in accordance with the Oxford Brookes University's policy on Academic Integrity. Data generated in the course of the research will be kept securely in electronic form (after it has been anonymised) in a specialist data centre. Data generated from paper questionnaires will be entered onto the electronic database and the paper copies will then be destroyed.

What will happen to the results of the research study?
The results of this study will be published as part of Catherine Lowenhoff's PhD and possibly in other publications, including peer-reviewed academic journals. The findings will be shared with the Institute of Health Visiting. From June 2016 onwards, you will be able to view a summary of findings here:

https://sites.google.com/a/brookes.ac.uk/lvs/

Who is organising and funding the research?
This research is organised by Catherine Lowenhoff, who is a Health Visitor and is currently a full-time PhD student at Oxford Brookes University. She is supervised by Professor Jane Appleton, Dr Nick Pike, and Dr Jan Davison-Fischer. Her PhD is funded by a Nigel Groome & Oxford Brookes University 150th Anniversary Studentship Grant.

Who has reviewed the study?
This research study has been approved by the Faculty Research Ethics Committee at Oxford Brookes University. The reference for this research study is FREC study number 2014/58.

What do I need to do if I want to complete the paper questionnaire?
Prior to completing the questionnaire please read and sign the survey consent form. When you have completed the questionnaire and you are happy for your responses to be included in the analysis, please post the consent form and the paper questionnaire back to Catherine Lowenhoff, the lead researcher. A stamped addressed envelope is provided for your use. You are under no obligation to complete and return the questionnaire.

Contact for Further Information
If you have any concerns about the way in which the study has been conducted, you should contact the Chair of the Faculty Research Ethics Committee at heabbott@brookes.ac.uk .
If you have any other concerns about the study please contact the Director of Studies, Professor Jane Appleton at jvappleton@brookes.ac.uk or the lead researcher Catherine Lowenhoff at Catherine.lowenhoff-2015@brookes.ac.uk

Thank you very much for reading this information and for any help with the questionnaire!

2.4 Survey Consent Form. This was incorporated into the beginning of the on-line survey or offered as a separate sheet to respondents returning postal surveys.

5.4. Survey consent form. This was incorporated into the beginning of the on-line survey or offered as a separate sheet to respondents returning postal surveys.

OXFORD BROOKES UNIVERSITY

Survey consent form

Title of Research: An examination of health visitor 'listening visits' in the context of their role in supporting mothers with mental health problems.

Thank you for your interest in this survey. Your help is very much appreciated. Your contribution will help to build a picture of what is happening in practice with regard to how health visitors support mothers with mental health problems.

This study is being organised by Catherine Lowenhoff, a health visitor, who is currently a full-time PhD student at Oxford Brookes University, in collaboration with the Institute of Health Visiting.

This survey will take about 30 minutes to complete. The cut-off date for submission of responses is 14th April 2016. Your responses are completely anonymous and there is no way of tracing the answers back to you. Some non-identifiable quotes from respondents may be used in presentations or reports.

From June 2016 onwards, you will be able to view a summary of findings here:
https://sites.google.com/a/brookes.ac.uk/lvs/
A summary of the findings will also be shared with the Institute of Health Visiting.

If you have any questions about the conduct of the study please contact the chair of the Faculty Research Ethics committee (heabbott@brookes.ac.uk)
If you have any questions about the study please contact Catherine's Director of Studies Professor Jane Appleton (jvappleton@brookes.ac.uk) or Catherine herself (catherine.lowenhoff-2015@brookes.ac.uk).

If you agree with the following statements and are happy to proceed with the survey, please tick the circles below.

- ❍ I have read the participant information sheet
- ❍ I understand that I am free to ask questions about the survey by contacting Catherine Lowenhoff using the email contact details given above.
- ❍ I understand that I may withdraw from the study up to the point that I post the questionnaire back to the researcher.
- ❍ I understand that the study has been reviewed and approved by the Research Ethics Committee of the Faculty of Health and Life Sciences at Oxford Brookes University.
- ❍ I consent to the use of anonymized quotes (made by me) in any publications of findings from this survey.

- ❍ I consent to participate in this survey

5.5. Paper version of survey (following pages). Identical questions were asked in the on-line survey.

2.5 Paper version survey (following pages). Identical questions were asked in the on-line survey.

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Health Visitor Survey

Title of Research:

An examination of health visitor 'listening visits' in the context of their role in supporting mothers with mental health problems.

Researcher:
Catherine Lowenhoff, Health visitor and PhD student

Supervisor:
Professor Jane Appleton

From:
Department of Psychology, Social Work and Public Health,
Faculty of Health and Life Sciences, Oxford Brookes University

Approved by the Faculty ethics committee:
FREC study number 2014 / 58

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THE SURVEY

SECTION 1. HEALTH VISITORS AND MENTAL HEALTH

Q1. As you know, the government has identified 6 high impact areas that should provide the focus for health visiting interventions. One of these is maternal mental health.
How confident are you that the majority of the following people (where you work) think that supporting mothers with mental health problems should be a core component of health visiting practice?

	not confident at all	not confident	neutral	confident	very confident
Local Authority Commissioners	❍	❍	❍	❍	❍
Managers of Health Visiting Services	❍	❍	❍	❍	❍
Health visitors	❍	❍	❍	❍	❍

Q2. Do **you** think that supporting mothers with mental health problems should be a core component of the work that health visitors do?

- ❍ Yes
- ❍ No
- ❍ Not sure

Q3. Do you think it is feasible to expect health visitors to be able to identify and support mothers with mental health problems?

- ❍ Yes
- ❍ No
- ❍ Not sure

Q4. The Health Visiting Core Specification 2015-16 states that maternal mental health should be assessed by health visitors at 6-8 weeks and 3-4 months postnatally.
How confident are you that the majority of the health visitors in your organisation are assessing maternal mental health at these times?

	not confident at all	not confident	neutral	confident	very confident
Health Visitor assessment of maternal mental health at 6-8 weeks	❍	❍	❍	❍	❍
Health Visitor assessment of maternal mental health at 3-4 months	❍	❍	❍	❍	❍

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Q5. Does your organisation have a protocol, policy or pathway in place that specifies what actions health visitors should take, and the sort of support health visitors should offer to women, when they identify mothers with mental health problems?

- ❍ Yes
- ❍ No
- ❍ Not sure

Q6. Does your organisation have a system for recording the following?

	Yes	No	don't know
The number of women who have their mental health assessed by health visitors.	❍	❍	❍
The number of women with mental health problems who received an intervention from a health visitor (to address their mental health needs).	❍	❍	❍
The number of women who no longer have a mental health problem at the end of an intervention from a health visitor.	❍	❍	❍

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SECTION 2. TRAINING IN PERINATAL MENTAL HEALTH

Q7. When thinking about the cumulative effect of all the training that you have received in perinatal mental health, please indicate your level of knowledge in each of these areas.

	Basic	Fair	Good	Very Good
Prevalence of common perinatal mental illnesses.	❍	❍	❍	❍
Normal biopsychosocial processes of pregnancy and adaptation to motherhood.	❍	❍	❍	❍
Factors that might make a woman more likely to suffer from a perinatal mental illness.	❍	❍	❍	❍
Signs and symptoms of common mental illnesses that might affect mothers during pregnancy and the year following delivery.	❍	❍	❍	❍
The importance of considering physiological/obstetric explanations for symptoms of mental illness (e.g. anaemia).	❍	❍	❍	❍
The potential impact of maternal mental illness on the mother.	❍	❍	❍	❍
The potential impact of maternal mental illness on the father	❍	❍	❍	❍
The potential impact of maternal mental illness on the foetus /baby.	❍	❍	❍	❍
Signs and symptoms indicating serious maternal mental illness.	❍	❍	❍	❍
The range of treatment options / interventions available to help mothers with mental health problems.	❍	❍	❍	❍
The range of interventions available to promote positive and reciprocal mother-infant interactions.	❍	❍	❍	❍
Ways of working with mothers to support the development of a therapeutic relationship.	❍	❍	❍	❍

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Q8. Do you use the skills and knowledge acquired from attending training in any of the following models or techniques in the work that you do with mothers with mental health problems?
Please indicate the extent to which you use each of these models or techniques when you are supporting mothers with mental health problems.

	Not At All	Occasionally	Frequently
Cognitive Behavioural techniques	❍	❍	❍
Non-Directive counselling techniques/ person-centred approach	❍	❍	❍
Family Partnership Model	❍	❍	❍
Promotional Interviewing	❍	❍	❍
Motivational interviewing	❍	❍	❍
The Solihull Approach	❍	❍	❍
Solution Focused Therapies	❍	❍	❍
Mindfulness techniques	❍	❍	❍
Relaxation techniques	❍	❍	❍
Facilitated/guided self-help	❍	❍	❍
Techniques to promote positive mother-infant interactions	❍	❍	❍

Q9. If you use models and techniques, that are not covered in the previous question, in the work that you do with mothers with mental health problems, please provide details in the text box below. OR, if you would like to say anything else about the skills and techniques you use when supporting mothers with mental health problems, please write your comments in the text box below.

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SECTION 3. LISTENING VISITS

Q10. The 2007 NICE guideline for antenatal and postnatal mental health recommended 'listening visits' as one of the evidence-based interventions for mothers with mild to moderate depression.
Please indicate what you think about 'listening visits' by clicking on the circle that seems to represent the best way of describing where you are on the continuum between the two opposite statements.

'Listening visits' are.....

Beneficial to mothers	❍	❍	❍	❍	❍	❍	❍	Harmful to mothers
Difficult for me to do	❍	❍	❍	❍	❍	❍	❍	Easy for me to do
Generally acceptable to women	❍	❍	❍	❍	❍	❍	❍	Generally not acceptable to women
Pleasant (for me)	❍	❍	❍	❍	❍	❍	❍	Unpleasant (for me)
Not relevant to me (I don't offer them)	❍	❍	❍	❍	❍	❍	❍	Relevant to me (I do offer them)

Q11. During any of the perinatal mental health training that you have attended, have you received training in how to do 'listening visits?'

- ❍ Yes
- ❍ No
- ❍ Maybe

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Q12. When you were learning how to do 'listening visits' did you have the opportunity to learn how to do them in any of the following ways?
If not, would you have liked to have had the opportunity to access any of these ways of learning? Please tick all that apply

	I had the opportunity to learn about 'listening visits' in this way	I would have liked the opportunity to learn about 'listening visits' in this way
Attending a workshop or lecture about 'listening visits'	❍	❍
Attending a series of workshops/ lectures about 'listening visits'	❍	❍
Watching video clips of 'listening visits'	❍	❍
Accompanying a health visitor on a 'listening visit'	❍	❍
Role playing what to do in a 'listening visit'	❍	❍
Observing a role play of a 'listening visit'	❍	❍
Another health visitor accompanying you on a 'listening visit' to observe you and then provide feedback	❍	❍
Having access to a more experienced health visitor to 'coach' you in what to do during a 'listening visit'	❍	❍
Having access to a more experienced health visitor to talk about how each 'listening visit' went immediately after the visit	❍	❍
Regular opportunities to discuss 'listening visits' in individual or group supervision sessions	❍	❍
Regular training updates	❍	❍
Access to a manual / handbook / book on how to do 'listening visits'	❍	❍

Q13. If you would you like to make any comments about the training that you have received in how to conduct 'listening visits, please give details in the text box below

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Q14. Do you think you have received sufficient training in how to deliver 'listening visits?'

- ❍ Yes
- ❍ No
- ❍ Maybe
- ❍ Not relevant. We do not offer 'listening visits' in our area.

Q15. Do you currently offer 'listening visits' to mothers with mild to moderate mental health problems?

- ❍ Yes
- ❍ No
- ❍ I do offer support but it is not called 'listening visits'

Q16. If you do not offer 'listening visits' to mothers with mental health problems, please could you explain why you do not.

Q17. Over the last five years, how many mothers with mental health problems would you estimate that you have you offered a package of support to that you would describe as 'listening visits?'

- ❍ 0
- ❍ 1-10
- ❍ 11-20
- ❍ 21-30
- ❍ 31-50
- ❍ 51+

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Q18. This question is about your professional practice. Please indicate to what extent you agree or disagree with the following statements.

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
I have a clear understanding of what is meant by 'listening visits'	❍	❍	❍	❍	❍
I have the necessary knowledge and skills to deliver 'listening visits' safely and effectively	❍	❍	❍	❍	❍
I feel confident in my ability to deliver 'listening visits'	❍	❍	❍	❍	❍
When I identify a mother with additional mental health needs I always offer 'listening visits' as an option of support to the mother	❍	❍	❍	❍	❍
I feel confident that the support I provide during the course of 'listening visits' will lead to improved outcomes for the women that I am supporting	❍	❍	❍	❍	❍
I have enough time to deliver the number of 'listening visits' I think are necessary	❍	❍	❍	❍	❍
I am able to offer 'listening visits' to every woman who I think needs them	❍	❍	❍	❍	❍
I find delivering 'listening visits' a rewarding part of my health visiting practice	❍	❍	❍	❍	❍

Q19. Do most of the health visitors in your organisation offer 'listening visits' as a therapeutic option to mothers identified with mild to moderate depression?

- ❍ Yes
- ❍ No
- ❍ Not sure
- ❍ Most of the health visitors do offer a package of support but it is not called 'listening visits'.

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Q20. These are some comments that some health visitors have made about 'listening visits.' Please indicate the extent to which you agree or disagree with these statements.

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
All health visitors should assess and support mothers with mental health problems	❍	❍	❍	❍	❍
Health visitors are not mental health professionals and therefore should NOT be supporting women with mental health problems	❍	❍	❍	❍	❍
The implications of maternal mental ill-health are far too complex for health visitors to deal with	❍	❍	❍	❍	❍
Too much time is spent ASSESSING maternal mental health and not enough time is spent on providing support to women with mental health problems	❍	❍	❍	❍	❍
Health visitors have had a little bit of training in a lot of different techniques. This makes it difficult to decide which techniques to use when providing support to women with mental health problems	❍	❍	❍	❍	❍
The term 'listening visit' does not adequately describe the support that health visitors give to mothers with mental health problems	❍	❍	❍	❍	❍
'Listening visits' are a bit of mystery. There doesn't seem to be any agreement on what they are or how to do them	❍	❍	❍	❍	❍

Q21. There may be other comments that health visitors have made about 'listening visits'. How do you perceive that health visitors in your organisation think about 'listening visits' and their role in supporting mothers with mental health problems?

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Q22. In your view, which of the following statements describe what is meant by 'listening visits?' Please tick all that apply.

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
The term 'listening visits' includes the offer of 4-6 visits (in the first instance) from a health visitor	❍	❍	❍	❍	❍
A 'listening visit' can be a stand alone visit	❍	❍	❍	❍	❍
Each 'listening visit' is expected to last about 45 minutes.	❍	❍	❍	❍	❍
'Listening visits' are always based on non-directive counselling or a person-centred approach	❍	❍	❍	❍	❍
'Listening visits' are always based on a cognitive behavioural approach	❍	❍	❍	❍	❍
'Listening visits' describe a package of care that may involve using a range of different techniques and interventions	❍	❍	❍	❍	❍
'Listening visits' involve using evidence-based information to help mothers regain their self-management abilities when these have been adversely affected by mental distress	❍	❍	❍	❍	❍
'Listening visits' include consideration of maternal well-being, the mother-infant relationship and family and social networks	❍	❍	❍	❍	❍
At the end of 4-6 'listening visits' an appropriate assessment tool is used to assess whether the mother's mental health has improved or not	❍	❍	❍	❍	❍

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Q23. If you would like to make any additional comments about what is meant by 'listening visits,' please do so in the text box below.

Q24. The updated NICE guideline for antenatal and postnatal mental health (December 2014) states that psychological and psychosocial interventions for mental health problems in pregnancy and the postnatal period should be based on the relevant treatment manuals. These should guide the structure and duration of the intervention.
Please respond to the following statements with regard to the support that you provide to mothers with mental health problems (which may or may not be called 'listening visits').

	Yes	No	Don't know/not applicable
Do you have a handbook/manual/guidance that informs your practice with respect to the structure and duration of the intervention that you offer to mothers with mental health problems?	❍	❍	❍
if you do have a handbook/manual/guidance - do you find it useful?	❍	❍	❍
If you do not have a handbook/ manual/ guidance - would you like one?	❍	❍	❍
Regardless of whether you have a handbook or not, would you say that there was agreement within your organisation regarding the structure and duration of the intervention that health visitors offer to women with mental health problems?	❍	❍	❍

Q25. If your organisation is using particular handbooks, models, methods or techniques to underpin the support that health visitors provide to mothers with mental health problems (which may or may not be called 'listening visits'), please give details.

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Q26. The NICE guideline for antenatal and postnatal mental health (December 2014) includes various statements about the delivery of interventions for mental health problems in pregnancy and the postnatal period (which are not necessarily called 'listening visits').
How confident are you that the following statements are true for the health visitors in your organisation?

	Not confident at all	Not confident	Neutral	Confident	Very confident
All health visitors receive regular high quality supervision relating to the support that they offer to women with mental health problems	❍	❍	❍	❍	❍
All health visitors use routine outcome measures to assess the impact of any intervention they deliver to address maternal mental health issues	❍	❍	❍	❍	❍
Health visitors involve women in reviewing the efficacy of any intervention they have delivered to address maternal mental health issues	❍	❍	❍	❍	❍
Systems are in place to monitor and evaluate treatment adherence with regard to health visitor management of perinatal mental health problems	❍	❍	❍	❍	❍
Systems are in place to monitor health visitor competence with regard to their management of perinatal mental health problems	❍	❍	❍	❍	❍

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Q27. If you would like to make any comments in connection with the statements in the previous question (supervision, outcome measures, maternal satisfaction, treatment adherence and monitoring health visitor competence), please feel free to do so in the text box below.

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SECTION 4. THE FUTURE : YOUR VIEWS MATTER

Q28. Do you think that the package of care that health visitors offer to mothers with mental health problems should be called 'listening visits'?

- ❍ Yes
- ❍ No
- ❍ Maybe

Q29. Do you think that the package of care that health visitors offer mother with mental health problems should be described as 'facilitated self-help'?

- ❍ Yes
- ❍ No
- ❍ Maybe

Q30. If you are not happy with the term 'listening visits' or 'facilitated self-help', do you have any ideas about a better way of describing/referring to the intervention offered by health visitors to mothers with mental health problems? Please share your ideas here.

Q31. Should the package of care include consideration of the impact of maternal mental ill-health on the baby as well as a range of possible interventions for promoting positive mother-infant relationships?

- ❍ Yes
- ❍ No
- ❍ Not sure

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Q32. What do you think are the key elements of an intervention framework that should underpin the work that health visitors do with mothers with mental health issues?
Please indicate the extent to which you think each of these elements should be included in an intervention framework to guide the support that health visitors provide to women with mental health problems.

Key elements of health visitor support for women with mental health problems	No opinion	No	Possibly	Yes
Developing a supportive, collaborative therapeutic alliance	❍	❍	❍	❍
Providing information about mental health problems and ways to overcome them	❍	❍	❍	❍
Communicating a normalising, recovery-focused message	❍	❍	❍	❍
Exploring thoughts, feelings and behaviour	❍	❍	❍	❍
Structured problem solving	❍	❍	❍	❍
Behavioural activation	❍	❍	❍	❍
Discussing exercise as a means of improving mental health	❍	❍	❍	❍
Exploring the link between nutrition and mental health	❍	❍	❍	❍
Discussing the importance of sleep, rest and relaxation	❍	❍	❍	❍
Providing opportunities to talk about relationships	❍	❍	❍	❍
Thinking about the impact of life events on mental health	❍	❍	❍	❍
Considering the interplay between physical health issues and symptoms of mental illness	❍	❍	❍	❍
Considering the possible relationship between alcohol, substance misuse and mental health	❍	❍	❍	❍
Exploring expectations of parenthood and mother's own experience of being parented	❍	❍	❍	❍
Observing mother-infant interactions, identifying problems with the mother-infant relationship and finding ways of helping mothers and babies to enjoy the time that they spend together	❍	❍	❍	❍
Observing and talking about self care, stress and coping	❍	❍	❍	❍
Recognising social isolation and anxiety and advocating ways of developing a sense of social connectedness	❍	❍	❍	❍

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Q33. In your view what needs to be done to improve the support that health visitors provide to mothers with mental health problems?

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SECTION 5 : ABOUT YOU

This is the last section. It would be really helpful if you could provide some basic information about yourself.

Q34. What year did you qualify as a health visitor? _____

Q35. What other qualifications do you have? (Please tick all that apply).

- ❍ Registered Adult Nurse
- ❍ Registered Children's Nurse
- ❍ Registered Midwife
- ❍ Registered Mental Health Nurse
- ❍ Registered Learning Disability Nurse
- ❍ Specialist Community Public Health Nurse - Occupational Health
- ❍ Community Practice Teacher
- ❍ 1st degree in subject other than health visiting (please give details)

  _____

- ❍ Masters degree (please give details)

  _____

- ❍ Clinical Doctorate / PhD
- ❍ Any other qualifications that you consider relevant to your role in promoting maternal mental health (please give details)

  _____

Q36. How many years have you been working as a health visitor?

_____

Q37. Are you..... (Please tick all that apply).

- ❍ A Fellow of the Institute of Health Visiting (iHV)
- ❍ A Perinatal Mental Health Champion for the iHV
- ❍ An Infant Mental Health Champion for the iHV
- ❍ Other (anything else that you think might be relevant to perinatal mental health - please give details)

  _____

Q38. Please provide the first three-four characters of the postcode of your workplace e.g. CO10. This is so that we can get an idea of the geographical distribution of the respondents. _____

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Q39. Are you working in an area that is receiving BIG Lottery Better Start funding?

- ❍ Yes
- ❍ No
- ❍ Don't know

Q40. Have you ever been part of a research project that involved training health visitors to provide support to women with postnatal depression or any other mental health problem that might occur during pregnancy or the year following delivery?

- ❍ Yes (Please provide brief details including lead researcher, location of research, the type of training you received and your role in the research project, if these details are known).

- ❍ No
- ❍ Don't know

Thank you very much for taking the time to fill in this survey. If you are happy for your answers to be included in the analysis, please return the questionnaire to me, Catherine Lowenhoff, in the envelope provided or send to:

Catherine Lowenhoff
Doctoral Researcher,
Department of Psychology, Social Work and Public Health,
Faculty of Health and Life Science,
Oxford Brookes University,
Jack Straws Lane,
Marston,
OXON.
OX3 0FL

If you have any other comments or queries please feel free to email me at Catherine.lowenhoff-2015@brookes.ac.uk

Appendix 3 Documentation relating to Delphi Consensus exercise – relevant to Chapter 8

3.1 Participation Information Sheet – Delphi Study

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Participant Information Sheet – Delphi consensus exercise.

Title of Research
An examination of health visitor 'listening visits' in the context of their role in supporting mothers with mental health problems.

What do I need to know?
You are being invited to take part in a research study. Before you decide whether or not to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully.

What is the purpose of the study?
The purpose of this part of the study is to discuss and review the core components and key clinical activities that underpin the work that health visitors do with mothers with mild to moderate mental health problems.

Why have I been invited to participate?
You have been invited to take part because you are a member of the Institute of Health Visiting.

Do I have to take part?
It is up to you to decide whether or not to take part. If you do decide to take part you will be asked to complete the attached consent form. You are still free to withdraw at any time and, as the voting system is anonymised you can also choose not to respond to particular questions if you do not wish to do so.

What will happen to me if I take part?
If you choose to take part, you will be asked to participate in a Delphi consensus exercise. This is a method for structuring a group communication process so that the process is effective in allowing a group of individuals, as a whole, to deal with a complex problem. It involves reviewing the core components and key clinical activities of interventions for mothers with mental health problems that have been identified from research and practice. Following small group discussion, each participant in this study will be asked to anonymously rate each component or activity by using an electronic voting system and to indicate whether the component or activity is desirable, feasible or probable in the context of health visiting practice. The researcher then collates all the responses from this exercise, excludes the components and activities that are not supported by the majority and organises the components and activities into a hierarchy according to those that are considered the most important by the group. A revised list of components and activities is presented to the group at a subsequent occasion, further discussion takes place and then the voting system is repeated. At a final meeting of the group, the results of the previous round of voting will be shared in the form of agreed components and activities. The final meeting will be an opportunity to discuss what this means for health visiting practice and to agree on a draft intervention framework. This method provides an opportunity to combine clinical wisdom derived from experience with evidence from research. The purpose of this study is to produce a health-

What are the possible benefits of taking part?
There will be no direct benefits to you, but this research may help to generate a better understanding of the health visitor's role in supporting women with mental health problems. This could lay the foundation for further research that might improve health visiting practice, and thereby could possibly improve outcomes for mothers and babies.

Will what I say in this study be kept confidential?
We will not ask for your name or contact details and you will therefore be anonymous to the researchers. Voting pads to be used in the audience response voting system will be randomly allocated and it will not therefore be possible to trace responses from named individuals.
.
What will happen to the results of the research study?
Data generated by the study will be retained for a period of ten years in accordance with the Oxford Brookes University's policy on Academic Integrity. Data generated in the course of the research will be kept securely in electronic form in a specialist data centre.

Who is organising and funding the research?
This research is organised by Catherine Lowenhoff, who is a Health Visitor and is currently a full-time PhD student at Oxford Brookes University. She is supervised by Professor Jane Appleton, Dr Nick Pike, and Dr Jan Davison-Fischer. Her PhD is funded by a Nigel Groome & Oxford Brookes University 150th Anniversary Studentship Grant.

Who has reviewed the study?
This research study has been approved by the Faculty Research Ethics Committee at Oxford Brookes University. The reference for this research study is **FREC study number 2014/58.**

Contact for Further Information
If you have any concerns about the way in which the study has been conducted, you should contact the Chair of the University Research Ethics Committee on ethics@brookes.ac.uk and the project's supervisor on j.fischer@brookes.ac.uk. You may also contact the lead research Catherine Lowenhoff by emailing Catherine.lowenhoff-2015@brookes.ac.uk

Thank you very much for reading this information and for any help with the Delphi consensus exercise!

3.2 Consent Form – Delphi Study

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Consent Form : Delphi Consensus Exercise

Title of research : An examination of health visitor 'listening visits' in the context of their role in supporting mothers with mental health problems.

Thank you for your interest in participating in this Delphi consensus exercise. The exercise is designed to combine the knowledge and experience of health visitors with research evidence of interventions that have been found to be effective in helping mothers to manage their mental health during pregnancy and the year after delivery. It is hoped that this exercise will contribute to the development of an intervention framework that will help to guide future health visiting practice.

If you agree to participate in the exercise, you will be invited to attend three meetings with the researcher, spread over a period of 6 months, between November 2016 and April 2017. At each meeting, the researcher will require 21/2 hours of your time to discuss the issues raised and to register your votes in response to a list of questions relating to the core components and key clinical activities of interventions to help mothers with mental health problems. This will help to build consensus about what aspects of their work health visitors feel are most important in relation to perinatal mental health.

A summary of the findings will be shared with the Institute of Health Visiting.

This research study has been approved by the Faculty Research Ethics Committee at Oxford Brookes University. The reference for this research study is **FREC study number 2014/58.**

If you have any questions about the study or your rights as a participant please feel free to contact the chair of the Faculty Research Ethics committee, Hazel Abbott, (heabbott@brookes.ac.uk), Catherine's Director of Studies, Professor Jane Appleton (jvappleton@brookes.ac.uk) or Catherine herself (catherine.lowenhoff-2015@brookes.ac.uk)

If you are happy to participate in this Delphi consensus exercise, please tick the boxes below and add your signature.

- ❍ The purpose of the Delphi study has been explained to me
- ❍ I understand that I am free to ask questions about the study by contacting Catherine Lowenhoff using the email contact details given above.
- ❍ I understand that I may withdraw from the study without penalty at any time.
- ❍ I understand that the study has been reviewed and approved by the Research Ethics Committee of the Faculty of Health and Life Sciences at Oxford Brookes University.
- ❍ I consent to participate in this Delphi consensus exercise.

Signed _____Date_____

3.3 Approval from Chair of Ethics Committee to extend period of study

Hazel Abbott
Re: extension of protocol for ethics aplication
To: Catherine Lowenhoff

20 June 2017 at 12:05

Dear Cathy,

Thank you for your email and also for meeting to explain this proposed minor amendment to your research protocol.

I am happy to give approval to extend the data collection phase of your study until after the September network meeting has taken place. Please let me know if you require any further extension to this time frame. if not, good luck with this final phase of your PhD research.

Best wishes,

Hazel

Please note: I am part time and my working days vary from week to week. It may therefore take longer for you to receive a reply to your email.

See More from Catherine Lowenhoff

Found in Sent - brookes.ac.uk Mailbox

Catherine Lowenhoff
extension of protocol for ethics aplication
To: Hazel Abbott

19 June 2017 at 07:33

Dear Hazel
Re : FREC study number 2014 /58
Following completion of the data collection for my Delphi study I have a meeting scheduled for the 27th June with the participants to feed back the findings to check that it is a fair representation of the work that we have done together.
As the purpose of the study was to gain consensus on the core components and key clinical activities of a draft intervention framework to inform health visitor support for mothers with mental health problems I will be presenting the framework at the meeting.
As it will be difficult for the participants to have time to think about the content of the intervention framework in any great detail during the meeting, I would like to ask them to reflect on the framework and bring their final comments to a meeting that they already have scheduled for September (the network meets every quarter).
I am therefore writing to you to request an extension of the ethics protocol for my study to include this extra element of feedback. I am anticipating that the feedback will take the form of an open, informal discussion. I will also supply postcards for participants to record key points arising from the discussion and any anonymous reflections that they would like to contribute.
Kind regards
Catherine

Catherine Lowenhoff MSc, MSc, PGCE, BSc(Hons), SRN, HV (dip), FiHV.
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Appendix 4 Supplementary Material

Publications (included)

Lowenhoff C (2017) Is it time for a review of the way that NICE guidelines are developed, presented and used to inform policy and practice? Evidence-based Nursing 20(3): 65-66

Lowenhoff C, Appleton JV, Davison-Fischer J, Pike N (2017) NICE guideline for antenatal and postnatal mental health; the health visitor role. Journal of Health Visiting 5(6): 290-298

Lowenhoff C, Davison-Fischer J, Pike N, Appleton JV (2019) Using the TIDieR checklist to describe health visitor support for mothers with mental health problems: Analysis of a cross-sectional survey. Health & Social Care in the Community 27 (5): e824-e836.

TABLE S1 - Conference Presentations

2016 - September	**Title:** If we are saying good-bye to listening visits, what does that mean for the way that health visitors support mothers with mental health problems? **Conference:** UK branch of International Marce Society Conference. **Type:** Oral
2016 - October	**Title:** If we are saying good-bye to listening visits, what does that mean for the way that health visitors support mothers with mental health problems? **Conference:** International Marce Society Conference 2016 Frontiers in Perinatal Mental Health – Looking to the Future. (Melbourne, Australia). **Type:** Oral
2016 - October	**Title:** 'Listening Visits': the Past, the Present, the Future. Sharing preliminary findings from a recent survey of health visitors. **Conference:** Oxford Health health visitor conference: The emotional transition to parenthood: holding the child in mind. **Type:** Oral
2017 - March	**Title:** Masterclass: Perinatal and Infant Mental Health: Driving the Future. **Conference:** IHV Conference: Evidence-based practice. **Type:** Oral
2017 - April	**Title:** Exploring the role of health visitors in supporting mothers with mental health problems: findings from a cross-sectional survey. **Conference:** RCN International Nursing Research Conference. **Type:** Oral
2017 - May	**Title:** Exploring the role of health visitors in supporting mothers with mental health problems. **Conference:** Oxford Brookes University Graduate event **Type:** Poster
2017 - July	**Title:** Health visitor support for mothers with mental health problems: using MRC guidance to re-design a complex intervention. **Conference:** European Academy of Nursing Science Summer School. **Type:** Poster
2017 - September	**Title:** Exploring the roles of health visitors in supporting mothers with mental health problems. **Conference:** UK branch of International Marce Society Conference. **Type:** Oral

PUBLICATIONS AND PRESENTATIONS - CONTINUED

TABLE S1 - Conference Presentations

2018 - June	**Title:** What should health visitors be doing to support mothers with mental health problems? **Conference:** CPHVA Regional Conference, Belfast. **Type:** Oral
2018 - September	**Title:** Combining evidence from research and practice to produce a draft intervention framework to guide the support that health visitors provide to mothers with mental health problems. **Conference:** IHV Perinatal and Infant Mental Health Conference **Type:** ePoster
2018 - March	**Title:** Session 1: Maternal Mental Health: essential component of health visiting practice OR an optional extra? Session 2: The Future of Listening Visits *or* Collaborating with HVs to develop a perinatal mental health intervention framework to guide their practice. **Conference:** East Sussex workshop **Type:** Oral
2019 - March	**Title:** Engaging with the health visitor workforce to improve services. **Conference:** Early Years Public Health: Westminster Briefing. **Type:** Oral
2019 - September	**Title:** Presentation 1: Reflections on using the MRC guidance for developing and evaluating complex interventions as a guiding framework for a mixed methods, multiphase research study. Presentation 2: A modified, real-time, technological Delphi study. **Conference:** RCN International Nursing Research Conference **Type:** Oral
2019 - September	**Title:** Accentuate the positive, eliminate the negative, latch on to the affirmative but don't mess with Mr Inbetween! **Conference:** IHV Perinatal and Infant Mental Health Conference: Relationships Matter. **Type:** Oral
2019 - September	**Title:** Thinking Outside the Box: New possibilities for perinatal mental health interventions derived from 5 years of searching the literature. **Conference:** UK branch of International Marce Society Conference. **Type:** Oral

An article has been removed from this version of the thesis due to copyright restrictions.

Lowenhoff C, Appleton JV, Davison-Fischer J and Pike N (2017) *NICE guideline for antenatal and postnatal mental health: The health visitor role*, Journal of Health Visiting 5(6)

Lowenhoff C (2017) *Is it time for a review of the way that NICE guidelines are developed, presented and used to inform policy and practice?*, Evidence-Based Nursing 20(3), 65-66

An article has been removed from this version of the thesis due to copyright restrictions.

Lowenhoff C, Davison-Fischer J, Pike N and Appleton JV (2019) *Using the TIDieR checklist to describe health visitor support for mothers with mental health problems: Analysis of a cross-sectional survey*, Health and Social Care 27(5), e824-e836